

Student Nurses' Perceptions of Compassion

Thesis submitted in accordance with the requirements of the University
of Chester for the degree of Doctor of Education

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April 2016

Student Nurses' Perceptions of Compassion

I declare that the material being presented for examination in this thesis is my own work and has not been submitted for an award of this or any other Higher Education Institution

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April 2016

Doctor of Education

Acknowledgements

I would sincerely like to thank my supervisors Professor Jeff Adams and Doctor Frances Atherton for their unconditional support, guidance and encouragement throughout my doctoral journey. I thank them for being patient with me as we travelled this journey together. I am a better person for having such inspirational academics who gave me their precious time and shared their intellectual knowledge when I needed it most.

I am also grateful to all the other wonderful, creative and inspirational lecturers who taught me while studying the Education doctorate modules. They opened up a world of knowledge that made me think differently, and for that I will be forever grateful. I would also like to thank the administrative staff, Emma and Rachel, for their help and support.

I am fortunate to have been sponsored and supported by the Faculty of Health and Social Care at the University of Chester throughout this doctorate.

My family have always been there for me, and for that I cannot thank them enough. Without their support I would not be the person I am today and my doctorate would not be complete.

I would like thank my friends and colleagues who have given me support and shown interest in my study.

Finally, I am forever grateful to my compassionate nursing students who believed in my study and gave up their time to share their perceptions of compassion with me. I can only hope I have done your stories justice and that your stories will make a difference to how others view compassion.

Dedication

For all my compassionate family, friends and student nurses
who enrich the world

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Student Nurses' Perceptions of Compassion

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Abstract

Compassion has been associated with the nursing profession since the days of Florence Nightingale. It is a general expectation that nurses should be compassionate when they are caring for people. In the United Kingdom (UK) concerns have been raised recently that nurses are failing to be compassionate as they carry out their nursing duties. There is little evidence within the literature of how student nurses perceive compassion as they engage in the pre-registration-nursing programme. In this study, I use narrative to produce case studies as a vehicle for the students to voice their perceptions of compassion. My ethnographic analysis of their stories is framed by my own experience as a professional registered nurse and nurse educator situated within their learning environment, and applies theories of compassion and learning. In my study, themes emerge that demonstrate commonalities, differences and tensions relating to the students' individual beliefs and behaviours, and to the impact of their professional development as they transcend from university learning spaces into clinical practice.

Summary of Portfolio Leading to my Thesis

Research methodologies for professional enquiry: This interpretive study explored appropriate methodologies to research the strategies that support student nurses' achievements in the theory components within the first year of their pre-registration programme. To do this I used an ethnographic approach utilising narrative analysis of three student nurses. I gained their perspective of how their beliefs and experiences affected their academic attitude and attainment. I found that a qualitative approach rather than a quantitative or grounded theory approach was the appropriate philosophy.

Social theory and education: This discussion applied differing theories to the history and development of the nursing profession. A feminist perspective was utilised and parallels were drawn between women's disadvantages and gender politics. I analysed the effect of influential theories and policies on women's labour from the time of Florence Nightingale to the recent present. This study revealed a number of ongoing influential issues within the nursing profession and nurse education.

Creativity in practice: This mixed method study explored which creative teaching methods could be employed to teach professionalism, compassion and dignity within the pre-registration nursing programme. A class of 12 pre-registration students were participants in the study. The approach I utilised was the idea that the students could learn through the pedagogy of drama. I found that being creative as a teacher and allowing creativity among students is important if we are to improve not only on their knowledge, but also their professional behaviour and values while making learning fun and purposeful.

Policy analysis: I analysed government policy in England on widening of access to higher education [HE]. The implications of this policy and subsequent changes to HE were discussed. I found that the widening participation policy has an influence on HE, but might not be as effective as the government wished at encouraging students from challenging backgrounds into HE.

Institutions, discontinuities and systems of thought: This small study investigated my professional role as a personal academic tutor (PAT). It took the form of a case study looking into the specific needs and responsibilities attached to supporting a student with learning needs from a PAT perspective. Cartesian and Hobbesian theories were used to analyse the institutional role of the PAT. The empirical data gathered was then interpreted from Kristeva's perspective of abjection. Through synthesis, this revealed discontinuities in the perceptions of the student, the institution and myself.

Thesis in context: This module drew upon all the previous modules and acted as a first draft for the proposal for my thesis. It included a literature review and the proposed research design. In particular, it enabled me to critically analyse alternatives and provide justification for the techniques used to investigate my research question.

Chapter 1: Background to the Study

1.1 Introduction

This background chapter outlines the rationale for the study I undertook to complete my doctoral journey as I locate myself as a nurse, a nurse educator and a researcher within the inquiry. I present the three pre-registration students whose narratives were instrumental in discovering what compassion means to them. I also introduce the research questions that I set out to answer on my journey of discovery as an ethnographer. I reflect on my previous experiences and knowledge that I have gained throughout my career, and refer to the first time that I became involved in a compassionate encounter with a person in the context of nursing. I conclude this chapter by signposting the structure that the remainder of the thesis takes.

Within the body of literature, government and nursing bodies agree that patients have a right to be treated with compassion (Prime Minister's Commission on the Future of Nursing and Midwifery, 2010; Department of Health [DH], 2013). It is apparent, however, that in some cases such as those highlighted within the Francis Report executive summary (Francis, 2013a, p.8) that "patients and those close to them" claim that these ideals of compassionate care are lacking within student nurses. Despite the importance of compassion within the nursing profession, few empirical studies have investigated student nurses' perceptions of what constitutes compassion and the learning and teaching of compassion within both clinical placements and the university setting.

It is therefore important for me to tell the students' stories, as I am aware of the influence of social, political and cultural tensions on the students as they navigate the pre-registration nursing programme (DH, 2011, 2012a, 2012b, 2012c, 2013). I asked three of my pre-registration nurses – Kat, Elizabeth and David (they chose their own pseudonyms) – for their perception of compassion; they told me their stories, exposing their knowledge of compassion in practice and education at a time when the importance of compassion is in the spotlight within healthcare in the UK.

The purpose of the study is twofold: to address the perceived void that exists in the student nurses' perceptions of compassion; and to explore the

learning and teaching strategies adopted within the pre-registration nursing programme that intend to develop understanding of compassion in practice. To fulfil the purpose of the study I seek answers to the following interrelated research questions:

- How do student nurses view the pedagogical approaches to learning and teaching compassion within the pre-registration programme?
- What do the students perceive to be contextual factors supporting training of compassionate nurses?
- What qualities or characteristics do students believe a compassionate nurse should exhibit?
- How do student nurses view the role of compassion within clinical practice?
- What fundamental beliefs and values do students think underpin compassion?

The study explores the personal stories of Kat, David and Elizabeth and captures their ideas of what they understand compassion to be and how they learn to be compassionate. The students openly discussed their ideas of compassion in different contexts. From these discussions, multiple related components emerged around their perceptions of compassion that they transposed between the university and clinical settings.

It was important to talk with the student nurses at length and to attempt to understand how they perceive compassion. I came to know more about Kat, David and Elizabeth through deep conversation, and the fact that they already knew me as an educator appeared to benefit, not hinder, the study. I am aware that I am in a position of power, but knowing me as an educator did not appear to subdue or perplex the students, and I could recognise that they trusted me: they trusted me as a fellow nurse, and they appeared to trust me enough to tell me their stories in their own unique way. It was during these conversations that the lecturer and student relationship changed as I was a radical listener to their concerns. Often without hesitation, they told me what they thought and believed, based upon their experiences. This study attempts to convey what compassion is like for them; and I become the medium by which they could express their understanding. They wanted to tell me what it is really like in practice: how compassion affects them, and its

effects upon their everyday practice and life. They spoke about things that moved them and which they perceived as all-important. The stories that the students wanted to tell should have exposure, so that nurse educators and policy makers understand what influences compassion and what it is like to be a student nurse at this time.

To find out and describe the students' views around compassion I used a multiple case study approach. Information was collected using semi-structured interviews which became more than conversation. Kat, David and Elizabeth's demeanour, actions and beliefs unfolded before me in the form of stories. From their audio-recorded stories, I was able to unpick their personal accounts, meticulously taking into account their individual perspectives. It was by unpicking their stories that themes emerged, and after unravelling the issues that were significant to them from an individual perspective I then looked across the cases to see if there were related topics important to all of them or topics unique to individuals.

In order to address the research questions it was not enough for me to depend on my own experiences. I therefore looked towards theories pertinent to the notion of compassion to underpin and make further sense of my interpretation of their narratives. However, my experiences as a nurse, nurse educator, and pre-registration curriculum programme leader have furnished me with personal knowledge that lets me tell their stories from an ethnographic perspective.

An ethnographic approach is entirely suitable to adopt throughout the research process as I obtain and analyse the stories that the students want to tell within a cultural group. Creswell (2007, p.70) says that ethnography is an appropriate design to use when studying the culture of a group – the beliefs, language, experiences and behaviours particular to them. Adopting an ethnographic lens allowed me to look at what the students revealed in their stories, which to those placed outside nursing might not be immediately recognisable.

My position as a nurse educator and a nurse involves teaching within the university setting as well as going into clinical practice to support the students. This helps provide enlightenment, broadening my view of what the students tell me influences the demonstration of compassion and its learning

and teaching within university and clinical practice. This inward gaze, albeit from the peripheries of their learning experiences, helps me make sense of their beliefs, behaviours and experiences in context and brings to the forefront knowledge that surrounds compassion, a perspective that we know very little about but assume is of utmost importance. The importance we place upon a nurse being compassionate is reflected in the pedagogical approaches we as educators use in learning and teaching, in both the university setting and the clinical setting where student nurses navigate their learning and practice (NMC, 2010, 2015).

The ethnographic perspective that I adopted led me to consider Etherington's (2004) notion that researchers require insight into the impact that personal experiences can have upon their research, and that researchers who take this exploratory route should explicitly situate themselves within their study. Adopting a reflexive approach as described by Pillow (2003) provides a formidable methodological tool to help prevent me from being overly indulgent within my study. Applying reflexivity throughout my analysis of the students' stories allows me to understand their views from their perspective, which is central to the study. Being reflexive and working through an ethnographic lens not only allows me to become immersed in the lived experiences of the students, but also helps situate me as the researcher. I can look inwardly to see what they see in the way that they see it as they tell their experiences of compassion.

1.2 Locating myself within the study

As Etherington (2004) points out, to explicitly situate myself within the research it is important I give an overview of my personal reasons for conducting the study that goes beyond my role as an educator. Devereux (1967) has said that when choosing their research topic, the researcher tends to choose a subject that has significant personal meaning and importance. I was aware of the personal importance that compassion has upon my professional and personal life, but it was during conversations with the students that the memory of my first experience of compassion within a nursing culture was awakened.

I experienced patient compassion in the initial few weeks of my nurse training; for the first time I knew what it was to be a caring, compassionate nurse. “Thank you for helping me” were the words spoken by a person who I was ‘looking after’, a stranger to me, but the event was more than an acknowledgement of the care I was giving: it was a life-changing experience. This happened within a ward environment, in the third week of my three-year nursing programme. Only the day before my cohort and I had been learning in the safe environment of the clinical skills laboratory how we should conduct a bed bath. Our clinical nurse lecturer had conducted the demonstration on a mannequin, then put us into teams of two and watched each team carry out the procedure on this lifelike doll. This demonstrating and enacting of the skill I now know is linked to the pedagogical approach of experiential learning (Benner, 2004). Advice was given in a proficient and professional manner by the clinical nurse lecturer, and included maintaining the person’s dignity and being caring and compassionate towards the person at all times. It was said in a manner that suggested the lecturer did not want me to probe, but I remember gathering courage and asking, “And how do we do that? How do we demonstrate compassion and caring at all times? What is compassion?” The lecturer did not answer me directly but said, “Just make sure that you are.”

The next day I found myself within a ward environment and carrying out the very procedure that I had practised the day before. The patient who I first carried out this nursing care upon was an elderly man, who appeared to have little strength to take care of his own hygiene needs. The moment was an epiphany as I experienced a feeling that I thought at the time could be compassion. I could also tell by the way the elderly man let me hold his hand: I believe that as we held hands, it became a reciprocal and mutual experience with eye contact that lasted longer than normal; it was in that moment that I was feeling compassion, and I felt he too was experiencing it.

Although I have had many encounters with patients that have been just as compassionate, this one has remained with me, embedded in my memory; it was a life-changing event that occurred at the beginning of my journey as a nurse and educator. As I look back, I realise that every patient that I have looked after has left some memory, their life footprint upon me. I

experienced this life-changing moment as significant because of the interaction, a reciprocal moment with a patient. It is with a more mature vision that I can look back and see that knowing every aspect of a compassionate encounter was necessary to lead me to a better understanding of it, even though these encounters often felt painful and sometimes even felt like an obstacle that I had to overcome to do the job I loved.

From that day compassion has remained an integral part of my philosophy towards healthcare, and one that I, too, try to convey to the students as I am now the educator, the clinical nurse demonstrating the principles of compassionate care within a university environment. The principles may remain the same and the demonstration of care upon mannequins have changed very little, but what I want to find out in my journey of discovery is if the students' educational needs for the compassion expected within the delivery of healthcare today are being addressed. We as educators continue to be trusted with introducing compassion as an integral part of learning about healthcare. Compassion, I believe, matters to how students practise now and as registered professional nurses in the future (NMC, 2010; 2015).

1.3 Outline of the thesis structure

To indicate how my study is organised I will now outline the remaining chapters of my thesis. Chapter 2 defines compassion in the context of nursing and highlights the role that compassion has within public and government agendas. I also look into the British National Archives to investigate the genealogy of compassion to see if recent concerns are unique to this time in history. Chapter 3 offers the theoretical background of ideas about compassion in students' learning, to support my analysis of my participants' stories. Chapter 4 discusses the methodological considerations of the study including the reflexive self, sampling procedure, data collection, analysis and ethical considerations. Chapters 5, 6 and 7 present the individual case studies of each student, and in chapter 8 critical reflections on findings across the cases are discussed, encompassing the central themes that emerged. I conclude my thesis in chapter 9.

Within this introduction to my thesis I have explained the background of the study and described its aims along with the research questions I set out to answer. I have introduced my participants, the three students who are the focus of my research, and how I have come to know what their perceptions of compassion are. I have established myself as an ethnographer, and located myself as a researcher who will use reflexivity to analyse the meaning of the students' narrative as they navigate their learning within a university and clinical environment. I have also suggested the importance that my study may have upon practice and pedagogy. The next chapter is an exploration of the concept of compassion in nursing within the UK context.

Chapter 2: Compassion – Historical and Contextual Perspectives

2.1 Introduction

To understand the concept of compassion in relation to nursing it is important to have a general overview of the definitions surrounding the words compassion, care and caring. These words are often used interchangeably within the nursing literature and the nursing profession, yet what each means in this context and how the meaning transposes to everyday nursing practice remain elusive (Schantz, 2007; von Dietze & Orb, 2000). I approach each one separately to analyse the concepts, as each forms part of the foundation of, and a thread running throughout, my thesis.

2.2 Defining compassion in the context of nursing

Purdie, Sheward and Gifford (2008) typify what is present within the literature regarding the generalised, multifaceted meaning that the word compassion conjures up. Compassion and caring often appear to be interchangeable (Schantz, 2007; Abraham, 2011; NHS Constitution, 2013).

I will define what is most commonly thought of as care within the National Health Service [NHS]. The NHS (2014) has suggested that care in the context of health is the management and interventions, which may entail a range of methods, that provide support to a person to help them to maintain their optimal health. To achieve the care required by a patient often involves different healthcare professionals coming together to work collaboratively. Storey and Holti (2013) support this, saying that healthcare professionals and healthcare workers do have their defined roles, and often work in teams, yet all individuals that make up the care team have equal responsibility to work together to provide the treatment the patient needs in a timely and effective manner. It appears that relational processes are at the core of care, as it is through professional collaboration and the processes of professional partnership that care can be delivered to an appropriate standard (Dewar, Mackay, Smith, Pullin & Tocher, 2010; Dewar & Nolan, 2013).

Within England, standards of care are monitored and guided by agencies external to the National Health Service such as NICE (2015) and the Care Quality Commission [CQC] (2015); and through National Service

Frameworks [NSFs] (2014). Internal monitoring occurs through policies and procedures overseen through clinical governance (DH, 2012a; McSherry & Pearce, 2003).

To deliver care and help maintain standards it is generally thought that a person has to have the personal quality of being caring: only a person who is caring can deliver care effectively. Caring or being a caring person is a significant attribute, thought to be at the forefront of compassion and compassionate practice. Pence (1983) Leget and Olthuis (2007) and Bradshaw (2009) support the idea that being a caring person leads to the delivery of compassionate treatment through compassionate practice. Recently, the thought that caring people are more likely to deliver compassionate care has become enshrined within the policy advocated by Health Education England [HEE] (2014). They too think that standards of care are affected by an individual's ability to be caring, and have initiated a values-based recruitment programme for both healthcare staff and students, including pre-registration nurses. The policy Values based recruitment (HEE, 2014) provides guidance for NHS employers, and is based upon selecting individuals whose behaviours and beliefs mirror the desired values. However, the policy does not take into account other factors, such as the lack of resources negatively affecting care (Patterson, 2010). Thus, caring in this context is purely based upon the underpinning personal qualities of the individual charged with delivering care that may affect the manner in which care is given to the patient and the standard of care delivered (Manley, Hills, & Marriot, 2011, p.35).

It is not often that the relationship between a caring healthcare professional and standards of compassionate care delivery is challenged. One person to do so is Smajdor (2013) in her controversial paper which challenges the assumption that caring is an obligatory characteristic for healthcare professionals to deliver quality care (p.3); she speculates that a patient can receive effective treatment without the person who provides it being caring towards the patient. To illustrate this Smajdor (2013) says:

Yet one can remove an appendix without caring about the person from whose body it is taken, empty a bedpan without caring about the patient who has filled it, or provide food without caring about the person who will eat it. (p.3)

She appears to be saying that if a person receives the care that they need, then it does not matter if compassion is part of the treatment as long as it is given efficiently.

The meaning of the word caring often becomes intertwined with the word compassion, and “making explicit which dimensions of care comprise compassion is challenging because of the often invisible nature of this work” (Dewar, 2013, p.49). The literature reflects an extensive range of theoretical perspectives of caring, both anthropological and psychosocial; none appears to mutually exclude the others, and collectively they complement each other. The foundation, however, appears concrete in that compassion/caring remains the basis of nursing (Watson, 1979; Leininger, 1998). Compassion remains a difficult concept to define and measure, as it remains a subjective entity. This is illustrated by Morse, Solberg, Neander, Bottorff and Johnson (1990) who in their comparative analysis of compassion/care suggest that there are five components of caring: caring as a human trait, caring as a moral imperative, caring as an affect, caring as an interpersonal relationship and caring as a therapeutic intervention (pp.2–3)

Compassion as a concept has led to the development of caring theories by such people as Leininger (1998) and Watson (1996) these researchers are very similar in the caring theories that they present. Watson’s (1996) theory of transpersonal caring, also called the theory of human caring or the caring model, has been influenced by many varied philosophical views. Watson (1996) herself postulates that the “theory of human caring” can be read as philosophy, ethic, or even paradigm or worldview (Watson, 1996, p.142). The caring theory that she presents mirrors the archetypical ideals of what is expected of a nurse: it not only upholds professional values and professional identity, but also endorses caring as an art that lets nurses attend to the needs of patients in a compassionate manner. Watson is also one of the few theorists who promote caring and compassion as being beneficial not just to the cared for, saying that it also benefits the caregiver. It helps nurses not only find meaning in the job that they do, but contributes positively to their wellbeing.

Nursing theorists such as von Dietze and Orb (2000), Cingel (2009) and Schantz (2007) have related compassion to nursing theory and argue that

compassion goes beyond sympathy, empathy, kindness and caring: they say that it is the intention to act upon the suffering of others. Peters (2006) supports this, and adds that it is a relationship in which personal emotions are triggered and that leads to actions to alleviate the suffering. Peters views compassion as “A deep feeling of connectedness with the experience of human suffering that requires personal knowing of the suffering of others” (p.39); these are feelings that occur between people and trigger emotion, which in turn “evokes a moral response to the recognised suffering and that results in caring that brings comfort to the sufferer” (p.39). In all of these definitions, compassion is a response to actions to alleviate suffering and that differentiates compassion from other similar qualities. Within the NHS Constitution for England (2013) a paragraph outlines what compassionate care in the NHS is:

We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person’s pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care. (p.5)

This statement brings together many terms associated with compassion, and sees it as an entity threading its way through care provided to patients. Because it is being used as a “central” element within care, it appears that both care and compassion are here being used interchangeably.

2.3 Compassion in public and government agendas

Compassion emerges as an integral element of the delivery of quality care that is important to the patient, their families and staff; it not only appears to be central to the actual or perceived experiences of patients, but is now becoming a fundamental element within government policies (Royal College of Nursing [RCN], 2012). However, student nurses in particular have been accused of delivering uncompassionate care by the media, who have used the ‘too posh to wash’ tag (Chapman & Martin, 2013); the tag was actually taken from a publication with a similar heading published as a response to the Francis Report (Beer, 2013). It has been noted by Hallam (2002), Fletcher (2007) and Gillett (2012) that information in newspapers influences

the opinions of the public. They also suggest that authors within the media can manipulate the truth to support their personal views, and in some cases sensationalise situations for their own benefit which may not reflect the general views of society.

The implication of being 'too posh to wash' a patient is not about the social class of student nurses, but is a veiled reference to the educational system now in place which trains nurses to a minimum of degree level. It is the ability of students to seek out best and research-based practice and be more effectively educated while working collaboratively in healthcare that is being viewed negatively in this context. Research by Watson and Thompson (2008) and more recently Aiken *et al.* (2014) found that nurses educated to degree level were significantly effective in preventing the deaths of patients in their care. The latter research helps support Willis's (2012a) view that nurses need to be educated to the standard required in a modern healthcare system to address the more technical and complex challenges that now form part of everyday caring for patients. The Willis (2012a) report found that it was wrong to suggest that nurses with degrees were less caring and compassionate, and there was a need to "dispel the myth that better educated nurses are less caring" (p.4). Such negative views can influence party policies: politicians are aware of the influence that national newspapers have upon their readers, and they too may manipulate policies and distribute information to reflect current public opinions (Druckman, 2005). There appears to be no other profession where education to degree level is seen as a negative attribute, and it appears that the long held perception of the compassionate student nurse is under threat.

In 2011, a television programme (Panorama, 2011) investigation into the care of people with learning difficulties revealed appalling uncompassionate care in a private hospital called Winterbourne View (since closed). Their substandard care resulted in government investigations and reports (DH, 2011; 2012; 2013), and as recently as June 2013 a further report was released documenting and making recommendations to improve compassion within nursing. *Transforming care: A national response to Winterbourne View Hospital: Department of Health review: Final report* (DH, 2013) was an accumulation of evidence of the uncompassionate care that had occurred at

Winterbourne View. The evidence led to the conviction of two qualified nurses and nine support workers for inhumane and uncompassionate care.

According to Keefe (2012), the public's opinion is that the level of compassion once inherent within nursing is diminishing, including within the student nurse population. The notion appears to be supported by high profile cases like the scandal that occurred in the Mid-Staffordshire NHS Foundation Trust; this was investigated and the findings published in the Francis report (2013a). In one part of the extensive recommendations, and written within the executive summary of findings under section 1.185, there is reference to the education of student nurses. It states that there should be "an increased focus on a culture of compassion and caring in nurse recruitment, training and education" (p.76). Although this does not say that it is not already inherent within the education programmes, it states that the teaching of compassion could and should be improved. After publication of the Francis report (Francis, 2013b), the NMC issued a response (NMC, 2013a); the professional body supported the findings of Francis and it, too, raised concerns regarding the training of nurses. The NMC raising concerns seems duplicitous at this point as they themselves state in section 35 that they "are responsible for setting the UK-wide standards for all pre-registration nursing and midwifery education" (p.14). They acknowledged that the changes to nursing programmes since the implementation of the "new education standards were set in 2010" (p.14) had gone some way to reflect Francis's concerns. This response by the NMC did not take into account the findings of Willis (2012a, 2012b).

The Willis inquiry came about as a result of concerns regarding the robustness of nursing education programmes raised by Francis in 2010 (DH, 2010). Based on these findings, the RCN (2012) commissioned an investigation into the system of educating nurses. The inquiry, headed by Lord Willis of Knaresborough, set out to explore if the areas of concern, particularly substandard care, were a direct result of failings in primary nurse education. The final report, issued in November 2012, contradicted previous held ideas, and particularly those held by Francis, that lack of demonstrated compassion was directly linked to poor nurse education programmes. Willis (2012a) wrote, "The commission did not find any major shortcomings in

nursing education that could be held directly responsible for poor practice or the perceived decline in standards of care” (p.6). Although this was an investigation into the effectiveness of pre-registration nursing programmes, there appears to have been minimal student nurse representation on it as only two student nurses sat on the panel of twenty four. The rest of the panel consisted of academics, members of professional and charity organisations, and qualified staff (Willis, 2012a). To further illustrate the lack of student nurse involvement, within the written evidence submitted to the panel there is only one mention of representation of student nurses: the Royal College of Nursing Students Committee submitted evidence, out of a total of eighty nine organisational submissions (Willis, 2012b). Therefore, it can safely be said that student opinions were under-represented within this report into student nurse education.

The concept of compassion within pre-registration nursing programmes is nothing new. The Willis Commission report (RCN, 2012) not only provides an historical overview of changes to the provision of pre-registration nurse education, from its transition from schools of nursing to higher education institutes [HEIs] which commenced in 1960, but also charts the importance placed upon compassion within the curricula. It was a major component of the professional standards of student nurses in 2004 (NMC, 2004), and continues to be embedded in the NMC standards for pre-registration nursing education (2010). The 2010 template for nursing programmes states, “the public can be confident that all new nurses will: practise in a compassionate, respectful way, maintaining dignity and wellbeing and communicating effectively” (NMC, 2010, p.4). There is of course some controversy into the effectiveness of realising standards: it is one thing to state them, it is another to realise them and measure their effectiveness (Mooney, 2009). Therefore, written standards can be seen as an aspirational trait, rather than a conditional attribute for a student nurse to acquire during their three-year training as a professional nurse (NMC, 2010).

Upholding this component within nursing is important not just within England; it has been documented by Hudacek (2008) and Goodrich and Cornwell (2008) as an internationally recognised component of nurse training. It is of special significance in the wake of reports from independent

and government agencies (Age Concern, 2006; The Patients Association, 2009; DH, 2010; CQC, 2011) who found that uncompassionate care had in worst-case scenarios led to preventable and early deaths of patients, and at best led to the distress of patients and their families. The changes and recommendations into lack of compassionate care and its prevention have failed to stop it occurring again; for example, the evidence of recent uncompassionate care in the *Selected summaries of investigations by the Parliamentary and Health Service Ombudsman, April to June 2014* (Parliamentary and Health Service Ombudsman, 2014). There are eight specific complaints in the document referring to cases of substandard and uncompassionate nursing care in England which were upheld by the Ombudsman (pp. 71, 78, 85, 126, 140, 157, 165 and 176).

Within this section, adverse incidents within practice, along with powerful public opinions and the formidable influence of the media, have been demonstrated to be drivers for policy changes that have a direct influence on the nursing profession (Hart, 2004; Chowdhry, 2010). The government responses and the ensuing policies are not only efforts to stop further occurrences of uncompassionate care, but can also be seen as political moves as the government tries to allay negative public opinions.

2.4 Human rights

Even though it is becoming evident within the literature that at times the human rights of patients are not being upheld, in law NHS organisations and healthcare providers have a duty to uphold them. In some cases this duty now goes beyond the organisation in which they work (Health & Social Care Act, 2008; CQC, 2015). The political impact of human rights on compassionate practice has been detailed in a number of recent reports.

The journey through recent political influences that have shaped practice encompassing compassion begins with the Health Service Commissioner for England, for Scotland and for Wales (1997, 1998) who voiced concern about the provision of compassion in healthcare. Leading on from this, in 2009 and in 2011 the Health Service Ombudsman issued a report that detailed failings in the delivery of compassionate care. Within this, ten examples from the 9,000 complaints received were documented as scenarios. It was apparent

that they presented “a picture of NHS provision that is failing to respond to the needs of older people with care and compassion” (Abraham, 2011, p.6).

The NHS Commissioning Board Chief Nursing Officer and Chief Nursing Adviser have stated that compassion within nursing is a key priority and integral to current government health agendas. The recent policy from the DH, *Compassion in practice: Nursing, midwifery and care staff: Our vision and strategy* (DH, 2012a), was launched to address the lack of compassion within practice, based on what have been coined ‘the 6Cs’ – care, compassion, competence, communication, courage and commitment. Two points within the document are particularly pertinent to student nurse practice and pre-registration nursing education: firstly, compassion is based upon effective relationships between the patient and the nurse, where the patient perceives the nurse to be empathetic and respectful (DH, 2012a, p.13); and second, that Health Education England will work with the education sector, employers, the regulator and staff groups to ensure that values and behaviours that are thought to add to compassionate practice are embedded in all nursing and midwifery university education and training (HEE, 2014, p.23).

Though the intent of the *Compassion in practice* document (DH, 2012a) is to improve and uphold high quality compassionate care, the implementation of the 6Cs appears to be reinventing policies, and indeed this fact is acknowledged (p.13). No further details of the origins of the concepts are included within the document, but investigation elsewhere leads to the conclusion that human rights form their foundations.

Human rights were embedded and implemented into the NHS as far back as the NHS Constitution. This came into effect as part of the Health Act in November 2009, based on the Human Rights Act (1998) which enshrined human rights into NHS practice and UK law (Equality and Human Rights Group, Department of Health and British Institute of Human Rights, 2007). In 2008, some four years before the launch of the 6Cs, and on the sixtieth anniversary of both the NHS and the Universal Declaration of Human Rights, the Equality and Human Rights Group (2008) issued *Human rights in healthcare: A framework for local action*. The then Secretary of State for Health, Alan Johnson, wrote the foreword and suggested that excellent care

within the NHS could not be achieved without integration of and respect for human rights. Knowledge of human rights was also thought to be fundamental to nurse education (NMC, 2010) and the NHS coined the acronym FREDa – standing for fairness, respect, equality, dignity and autonomy – but even within this framework whose purpose as to “assist NHS organisations to develop and use human rights based approaches (HRBAs)” (Equality and Human Rights Group, 2008, p.4), the standards that could be reasonably expected within the NHS fell short (Francis, 2013a).

Judging by its assistance in supporting and improving care and compassionate practice, the integration of human rights into the NHS appears unsuccessful. An example of where care and compassion have been deficient within England and Wales is documented in figures from the Office for National Statistics (2013) in their publication *Mortality statistics deaths registered in England and Wales, 1993-2011* where table 4 details the deaths of 1,187 people who died in 2011. These deaths were caused as a direct result of patients being denied the human right to life within either a hospital (total = 944) or nursing home environment (total = 132), and were directly due to inadequate provision or withholding of nutrition and hydration, and documented on death certificates as due to malnutrition or dehydration (Office of National Statistics, 2013, table 5).¹ In 2012 the number of deaths related to malnutrition in NHS hospitals in England and Wales was documented: 47 had malnutrition as the underlying cause, and a further 286 mentioned malnutrition on the death certificate (Office for National Statistics, 2012). These statistics reveal that the human right to life is not being upheld in some instances within healthcare provision, and highlight that patients are still suffering and even dying through the absence of compassionate practice. Clearly, safeguarding of patients through compassionate practice is more complex than implementing policies and laws.

Even though the implementation of FREDa and the 6Cs appears to have failed to stop uncompassionate care, the human rights approach to healthcare regulation has been embedded within the work of the Care

¹ The remainder of deaths, from malnutrition and dehydration occurring outside hospitals and nursing homes, were listed under ‘other places’.

Quality Commission (CQC, 2014a), whose role is to check if both NHS and public healthcare services meet national standards (Wilkinson, 2014). Two more aspects have been added to the five principles of FREDA. They are the right to life and the rights of staff working in services. This was a direct result of changes made to the Care Bill (2014) that extended the Human Rights Act of 1998 to people using adult social care services who were not previously covered. It is noteworthy that this happened as late as 2014.

Within the consultation prior to the CQC implementation of the changes to the Care Bill (CQC, 2014a), within appendix two in the professional representatives section, nursing is represented by a nursing union (the RCN) and not by the NMC, the professional body for nursing. Input from the professional body of nursing, student nurses and nursing academics may have helped ensure that human rights were emphasised from their perspective; likewise, in the strategic partners section there is no mention of any contribution from HEE. This raises the question of the absent contributions, opinions and voices not only of student nurses, but also of the academics who are commissioned to train compassionate caring nurses.

By looking into the history of compassion within nursing, it becomes apparent that uncompassionate care is not a particularly new concept.

2.5 Compassion considered historically

The following section presents a short historical overview of the role of compassion within nursing, and the contributing factors highlighted by one general practitioner (GP) in the nineteenth century as leading to substandard care of patients. Critically analysing historical documents and comparing them to the findings of the Francis report (2013a, 2013b) allows me to see any themes present then that still arise today.

Though sparse, historical evidence of nurses allegedly lacking compassion is documented as far back as 1847. This is evident within the British National Archives and becomes obvious in a letter from GP Thomas Tatham to the Chairman of the Board of Guardians, both based in Huddersfield. This board had responsibility for running a workhouse that not only provided work and shelter for those unable to support themselves, but also provided care for the sick in the fever hospital situated within it. It is the

substandard compassionate care of the fever patients to which Tatham refers; in the letter he makes a number of pertinent points referring to the reasons care was uncompassionate, points which resonate with similar occurrences documented in the Francis report (2013a).

The letter Tatham (1847) wrote begins by apologising for having to write to the board and says that he felt compelled to write to them with his concerns so that it would help improve care now and in the future. Tatham's concern to correct present and future practice, although published some one hundred and sixty six years earlier, reflects what is contained within the executive summary of the Francis report (2013). Francis (2013, p.5) said that the systems in place to ensure acceptable care delivery had failed, and that the report was there to highlight the shortcomings that had led to failures in the standards of care so they did not happen again.

Tatham points towards the importance of helping to support the vulnerable with their nutritional needs, noting that patients who are too weak to feed or help themselves are very much neglected. This too is reflected in the Francis report (2013a, vol. 1, p.129) which says patients were also neglected rather than helped to maintain both their nutritional and hydration needs. Tatham writes about the lack of care being obvious as he observed seeing patients left lying in their own excrement for days at a time, while present in the Francis report executive summary (2013a, p.13) is the acknowledgement that patients were also left in their own excrement and in soiled bed clothes over long periods.

Tatham goes on to highlight and conclude his concerns, and turns to what he views as the importance of educated nurses to the successful recovery of patients. He specifically comments on how patients looked after by pauper nurses were at a heightened risk of harm compared to patients cared for by the trained nurses of the day.

When he wrote about pauper nurses, I deduce that he was referring to members of the workhouse who were elected to or were allocated the task or job of looking after the sick within their community. These pauper nurses were more often than not untrained and illiterate in comparison to the 'trained proper paid nurses'. Nursing at this time was undergoing changes: care of the sick had long been provided by members of religious orders, including

the Protestant Sisters of Charity (Rivett, 1986). This order trained nurses for private work who often gained further experience within the wards of Guy's and St Thomas's hospitals in London. Burdett (1900, p.556) says the reputation and training of these nurses helped provide the best evidence-based practice available at the time.

Tatham goes on to refer to the standards and importance of nurse education that could affect patient care and mortality, and describes the substandard care and compassion that was contributory to people's deaths. Tatham may also have been the first person to recognise the distress and emotional labour (Hochschild, 1983) that continually looking after the sick can have:

Robert Worth is the only nurse in that Hospital who can read and write[.] [F]or a week or two he did his duty; He then became ill of a fever and was confined to bed a fortnight, since that fever he seemed to be disgusted by his occupation and is become reckless. (p.1)

Tatham appears to think that education played an instrumental and positive part in the provision of compassionate and optimal care, and this could be one of the first recorded examples of compassionate burnout. He indicates that when the nurse contracted an illness from the very people he was helping, it had not only impacted upon him personally but that his care had become 'reckless'; his behaviour had changed and patients in his care had become compromised.

Francis also refers to the importance of educated nurses and indicates that reasons for poor care include "Deficiencies in initial and continuing training; Undervaluing of the nursing task and those who perform it" (Francis, 2013a, vol. 3, p.1459). Comparable to Tatham's observations that pauper nurses were not as effective as trained nurses, within volume 3 Francis goes to some length to expand on the importance of educating health care support workers (HCSWs). Francis reflects on the delivery of appalling care by HCSWs in Stafford, and refers to the protection of patients through transparency and protection from being exposed to "care and treatment by people who are unfit, unqualified or incapable of performing their duties to an acceptable standard". Expanding on the value of educated and trained nurses (as Tatham had), Francis concludes by referring further to the role of

HCSWs: “They undertake work that, if not carried out or if undertaken carried out badly, may endanger patients’ health” (Francis, 2013a, vol. 3, p.1535)

With this comparison of care afforded to the sick in 1847 and that evidenced in the Francis report (2013, 2013a), it appears that some of the causes of unacceptable delivery of care have not changed over the years. There have been improvements such as research-based interventions within nursing, medicines and technology; but there are also elements of care that continue to be viewed as uncompassionate, and care falling below minimal healthcare standards is still present within today’s healthcare systems.

2.6 Summary of chapter 2

Within this discourse of compassion are emerging themes: firstly, that uncompassionate care within nursing is historical and continues to be problematic; and secondly, that students’ voices are under-represented in the nursing literature, policy documents and educational reports. The importance of hearing student nurses’ voices is nowhere more apparent than Willis’s (2012a) statement: “Valuing what students bring to their education is crucial: they are the leaders of tomorrow and it is their voices that must be heard.”(p. 5). Yet within the literature it appears that their voices have not been given the platform from which they may have a positive impact on the delivery of compassionate care. There also appears to be a difference in perceptions between what the public thinks is occurring and evidence from the recording and reporting of uncompassionate care by student nurses. There are also opposing conclusions in Francis (2013a) and the independent inquiry by Willis whose emerging reports (2012a; 2012b; 2012c) say that the educational programmes through which student nurses are trained are fit for purpose: “The foundations of high quality modern nursing education are already in place... and has no negative effect on the compassionate practice of student nurses” (Willis, 2012a, p.4). This raises the question of why uncompassionate care is still occurring: exploring what student nurses’ personal perceptions of compassion are may contribute positively to the provision of healthcare services.

Chapter 3: Compassion in the Context of Learning

3.1 Introduction

Leading on from the previous chapter, I now discuss theories that relate to compassion and are thought to influence both the demonstration and the learning of it. I first look at the role that emotions and associated theories have upon student nurses' ability to learn and demonstrate compassion. I then investigate the impact of learning theories upon the pedagogical approaches taken within the pre-registration nursing programme, and how certain approaches to teaching and learning compassion may be conducive to compassionate learning.

3.2 The role of emotions in compassion

Lazarus (1991) Haidt (2003) and Nussbaum (1996, 2001) highlight the substantial interest in the effect that emotions have on a person, and the contribution that they make to a person's ability to demonstrate compassion. It is therefore important to understand the contribution that emotions have upon compassion and compassionate practice. Emotions within nursing are, as Miller (2002, p 588) says, "an integral part of the workplace", suggesting that experiencing emotions is important when looking after people in caring situations and that emotions are fundamental to compassionate practice. Deigh (2004), Pence (1983), and Wear and Zarconi (2008) add to the discussion, particularly of labelling or categorising the emotions a person experiences, saying it is difficult to agree upon what constitutes an emotion. Kringelbach and Phillips (2014, p.6) illustrate this when they cannot decide whether "such things as guilt or love are actually emotions, or something else", and they appear at a loss to explain what these experiences are if not emotions. What does seem to be agreed, and important within nursing, is that emotions or experiences precipitate a chain of behavioural, cognitive and physiological changes. These changes within a nurse can lead to an internal response that may result in the nurse feeling or being compassionate (Sprecher & Fehr, 2005; Goetz, Keltner & Simon-Thomas, 2010).

Often, people who find themselves in caring situations refer to how they 'felt' or the feelings they experienced, and use the words 'compassion',

'emotions' and 'feelings' interchangeably so the words and meanings become entwined. Prinz (2005, p.5) says that "According to one strand in folk psychology, emotions are feelings; they are phenomenally conscious mental episodes." There are subtle but nevertheless important differences between feelings and emotions that I will expand upon. It is my experience that when nursing students talk about feelings – for example, feelings of sadness, happiness or perhaps being frightened – it is really not feelings to which they refer; instead they are often talking about emotions that they have experienced. Emotions according to Gross and Thompson (2007) are different from feelings: feelings are the precursor to emotions, as the experience of feelings or feeling 'something' acts as a medium. These encounters affect thought processes that trigger an emotional response; therefore it could be that emotions are the direct response to the experience of feelings (Lazarus & Folkman, 1984; Oschner & Gross, 2007; Purdie, Sheward, & Gifford, 2008).

The trigger(s) to these emotional responses are encounters or the feelings that are experienced, the experience being initiated through the activation of physical sensations that cause a physical reaction (Kassam & Mendes, 2013). The physical sensations that we feel are facilitated through the five primary human senses, which are vision, smell, hearing, taste and touch (Tortora & Derrickson, 2009). I say primary, as there are thought to be more, although these are lesser known but still important senses; Plutchik (2001) gives us an example as he refers to eight primary emotions of which all variations of emotion are a consequence. The consensus, however, is that feelings or sensations are triggered by experiences because of an encounter, and through the senses the brain deciphers these feelings or sensations leading to emotional experiences (Myers, 2004).

Gross (2001, p.497) has discussed the role of "emotion regulation" by which feelings give rise to emotions. He says that feelings and therefore the type of emotion that a person experiences are controllable, and therefore so is how they act when they occur. When applied to nursing, feelings have a role within compassion: it is personal feelings, personal perceptions within clinical practice and distressing situations, that in many cases trigger an emotional response (James, Andershed, Gustavsson, & Ternstedt, 2010).

Emotions when triggered affect cognitive processes that prompt a person to act in a manner that endeavours to alleviate suffering and distress. Gross (2001, p.498) says, "Emotions are thought to arise when an individual attends to a situation and understands it as being relevant to his or her current goals." Appreciating personal feelings and emotions experienced within the nurse/patient relationship can encourage a nurse to act; they can become a prompt that helps enable a nurse to respond positively and helpfully in challenging situations. Hayward and Tuckey (2011, p.1502) state, "When an individual attends to an externally psychologically relevant situation, the situation is appraised to imbue it with personal meaning and relevance."

Although there are many theories of emotion, there are four that are perhaps more recognised and referred to. The first is the evolutionary theory, that emotions are both adaptive and inherited and they help us to survive and learn (Darwin, 1872/2007). The second is the James-Lange theory (cited in Lange, 1994), which suggests that human emotions occur because of physiological reactions to events and their personal interpretation. One example in relation to nursing may be coming across a situation that is personally frightening. The experience results in physiological changes such as the release of adrenaline that may cause symptomatic shuddering and tachycardia (Schmidt & Weinshenker, 2014). The James-Lange theory advocates that interpretation of the physiological changes occurs and cognitive interpretation results, for example in being frightened. The Cannon-Bard theory directly opposes the theory of James-Lange, suggesting that our emotions affect physiological states. Proponents say that when a situation is frightening the response may be crying or shuddering; but this is a direct result of our emotions and not because of the physiological changes that occur simultaneously. Sullivan (2009, n.p.) is succinct when he defines this theory: "This theory defends the view that emotion-eliciting stimuli or events trigger physiological arousal and the experience of emotion simultaneously and independently." Finally, Schachter and Singer (1962) put forward a theory that a person needs to first have and then interpret a bodily response to an emotion. The effect that the emotion has on bodily response and the person's emotional reaction are dependent on where that person is and the

situation they find themselves in. For example, if the heart is racing because the person has been involved in an emergency, it may be interpreted as fear; if the heart is racing because the person has saved a life, then this may be interpreted as exciting.

To explore further theories pertaining to emotion, I will first expand on the evolutionary theory of emotions which can historically be traced back to Charles Darwin in his work within *The expressions of the emotions in man and animals* (1872/2007). Darwin (1872/2007) suggested that emotions have a purpose and had evolved because they help people survive; by enabling people to act in a way to enable self-preservation, emotions have an adaptive purpose to help prevent physical harm. Eisenberger, Jarcho, Lieberman (2004) who agree that it has been an evolutionary process to protect the human species from physical harm, but also extend the theory to that of protection from social pain. Darwin's theory does have its criticisms, one being that he did not actually define the term emotion (Hess & Thibault, 2009). This is of little surprise: he may have purposefully left the definition open to interpretation, as emotion is almost impossible to define. Goldie (2007, p.928) has said that the multiplicity of factors that contribute to emotional phenomena make it especially hard to provide a complete description of what an emotion is; this has led theorists to not only differ over the fundamental properties of emotions, but also give comprehensive examples. As a point of note Tangney and Fischer (1995) wrote:

All but radical social-constructionists accept that emotions have an evolutionary basis. Some emotions and moods, such as happiness, love, sadness, anxiety, anger and shame have been taken up into many human cultures. The wide variability of emotions of sexual love, anger, anxiety, shame and many other emotions in the East and West and in industrial and non-industrial societies, can be understood in terms of human emotional propensities that are elaborated into culturally functional patterns. (p.168)

The feelings experienced when providing compassionate care within a nursing context can cause a nurse to undergo mixed 'emotional reactions'. Morse, Bottorff, Anderson, O'Brien, & Solberg (1992) document the positive aspects of the nurse-patient interface, and that overall nurse-patient interactions usually result in positive experiences for both patients and

nurses. This occurs as information passed between them using appropriate and varying communication skills typically leads to actions to relieve the anguish (Riley, 2012). The patient benefits by having the suffering relieved, and the nurse benefits by relieving the anguish and not then being part of the distressing scenario.

Even when a nurse has relieved suffering, there are times when nurses can internally perceive some of the emotions that lead to a positive experience for patients as negative. This internal disconnect between positive outcomes and inner disquiet can occur due to nurses experiencing emotions unacceptable to express within the nursing environment in their interaction with patients and their loved ones. For example: the feeling of emotional lability when witnessing or experiencing distressing events; nurses have, in these instances, to curtail their emotions so they can function effectively within the role (Hochschild, 1983; Tracy, 2005).

The general expectation is that nurses are expected to manage their emotions, and the emotions of significant others take precedence over those of the nurse. It is generally thought that nurses have to control their emotions in a caring habitus and reflect appropriately the expected level of emotions. Hochschild (1975, 1979, 1983) refers to this suppression of emotions as emotional labour, and it was in her research into the work of flight attendants that emotional labour was first conceptualised. The idea emerged that emotional labour was associated with service sector workers, and is described by her as “The induction or suppression of feeling in order to sustain an outward appearance that produces in others a sense of being cared for in a convivial, safe place” (1983, p.7). Within her research she too looked towards theories such as Darwin’s, before presenting her own interpretation, a new “social theory of emotion” (Hochschild, 1983, p.218). The theory of emotional labour was soon adapted into nursing (Siviter, 2012).

Emotional labour can also be used to regulate emotions within organisations. The principles of emotional regulation have been researched using a number of professions as the subject, and although the emotions experienced within the different professions may vary, the theory of emotional regulation can be applied to all (Smith, 1992; James, 1992; Bolton,

2000). This regulation may be individualised or organisation-based, and used to train people in how to deal with emotional challenges within the workplace (Smith & Lorentzon, 2005; 2007; James, 1993). Hochschild's theory is not without its critics (Burkitt, 1997, 2002): for instance, Theodosius (2006, p.893), referring to the work of Burkitt (1997, 2002), has suggested that it "prioritizes external social factors at the expense of unconscious ones". This ability to regulate emotions lends itself to the idea that controlling of emotion is a learned or imposed behaviour or coping mechanism (Mason & Rowlands, 1997). The method of coping can be directly related to nursing experience, and to dealing with the immense variety of emotional situations that arise within the caring environment between nurses and their patients (Smith, 1992).

The theory of emotional labour in nursing that was enhanced by Theodosius (2006) can be linked to that of student nurses as they learn to control their emotions on entering the profession as novice learners. Experiencing emotional arousal is thought to have a more profound effect on learning than affective processes have. Within their training, nurses learn and experience an array of emotions and appropriate emotional responses (Lewis & Haviland-Jones, 2004). This relates to the work of Dreyfus (1981) and Benner (1982) who both relate skill acquisition as a learning process: when a person begins their training they start as a novice learner and progress towards becoming an expert. Being able to control their responses to their emotional experiences and the learned ability to control their emotions may be viewed as skills acquired through learning experiences. As Benner (1982) herself has said when referring to personal emotional challenges of student nurses:

Illness, pain, disfigurement, death and even birth are, by and large, segregated, isolated experiences. It makes little sense for the lay person to personally prepare in advance for the many possible illness experiences. Nurses, in contrast, through their education and experience, develop and observe many ways to understand and cope with illness, as well as many ways of experiencing illness, suffering pain, death, and birth. Nurses offer avenues of understanding, increased control, acceptance, and even triumph in the midst of what for the patient, is a foreign, uncharted experience. (p.135)

Benner (1982, 2015) believes that emotions experienced within nursing are unique: even in the event that a person has had previous experience within the caring professions, the professional role which they enter into as a student nurse brings new and distinct responsibilities. Although every emotional encounter has exclusive properties which are never truly replicated, this is not to say that previous experience cannot be incorporated into unfolding events, and as “emotions and their response patterns are not fixed, they can be manipulated to change the type, intensity, duration and trajectory of emotions likely to be experienced” (Hayward & Tuckey, 2011, p.1502).

While it may be viewed as inappropriate to demonstrate sadness, anger or emotional pain within the caring setting, this does not necessarily mean that student nurses are not feeling or experiencing emotions. Their experiences can vary across a spectrum from intense to mild emotional events. These can happen at any time, last fleetingly or for a longer time, and have no, minimal or lasting effects such as prolonged stress or anxiety (James, 1989; Smith, 1992; Rafferty, 1998). Tracy and Tracy (1998, p.407) have referred to this controlling of emotions and behaviour as “double-faced emotion management”, meaning that a nurse employs a facial mask and pretence as part of their outwardly seen behaviours, to act and help the patient and others professionally while they themselves are experiencing distress. This double-faced emotion management has also been identified within the research presented by Hochschild (1983) who goes on to identify that there are multi-layered depths to managing emotions. When referring to Hochschild’s work, Hayward and Tuckey (2011) identify this multi-layering as “deep and surface acting” (p.1502). These individually defined activities regulate emotions that can be used by the nurse to not only manage the patient’s understandings and attitudes, but also used personally to “align their own behaviour with organizational and professional expectations” (p.1502). Of the two, using deep acting to mask emotions is thought to be less harmful to the person because “it involves active effort to align inner feelings and observable behaviours with these expectations”, as opposed to surface acting which “has been associated with feelings of inauthenticity,

alienating the professional self from felt emotion” (Hayward & Tuckey, 2011, p.1502).

Relating these thoughts to the emotions experienced by student nurses, there will be times that tensions occur between the professional self and the inherent, personal self. These tensions can lead to students experiencing emotional personal trauma related to emotional burnout (Deary, Watson & Hogston, 2003). When student nurses experience emotions that manifest in psychological problems, these can be associated with post-traumatic stress disorder (PTSD) which can occur in those who are involved in distressing incidences within the habitus where they work. This emotional trauma, by very fact that it has an adverse personal effect on the nurse, will therefore impact negatively upon compassion (Laposa, Alden & Fullerton, 2003).

Strongly associated with emotions is empathy: when a nurse is able to empathise and demonstrate empathy towards patients, not only are their physiological needs met, but it enables the nurse to provide psychological care as well (Baillie, 2005; Parker *et al.*, 2007). These thoughts have been challenged (Morse, Anderson, *et al.*, (in press); Diers, 1990) as to the value and therapeutic benefits of empathy, their consensus being that to display or be empathetic to patients within the clinical setting may not always be appropriate as the patients come to terms with their predicament.

There is not one all-encompassing definition of what empathy means, but consensus that it occurs through engagement with another person. This occurs with such intensity that the person becomes immersed in what the other person is experiencing. It is “more than just listening, attending, observing, and responding to another person with unconditional positive regard” (Stebnicki, 2007, p.322). By becoming immersed, an understanding of their suffering from their perspective occurs, taking cognitive thought of how the person must be feeling and their “private logic” (Egan, 2010, p.13). Beddoe and Murphy (2004) offer as a definition “...the capacity to understand and respond to client emotions and their experiences of illness” (p.306), while Hojat (2009) defines empathy as “a predominantly cognitive (rather than emotional) attribute that involves an understanding (rather than feeling) of experiences, concerns, and perspectives of [another person], combined with the capacity to communicate this understanding” (p.413).

Howe (2013) supports Hojat, and suggests that cognitively empathy is based upon perception, visualisation and situating oneself in another's position. It involves actively thinking about what another person is experiencing and feeling.

There are two types of empathy a person may have: it being an innate quality, and one that has been taught and learned (Williams & Stickley, 2010). This cognitive involvement requires a student nurse to engage not only with their personal feelings and emotions, but to also to experience as nearly as possible what the patient is suffering. Sheehan, Perrin, Potter, Kazanowski and Bennett (2013) support these thoughts and say that "Empathy involves being present to another person in a very personal way so that there is an authentic understanding and experiencing of another's feelings" (p.457). This authentic understanding is also thought to be what morality is based upon. These moral judgements may not be easily and logically explained, but are based on intuition to do what feels right at the time (Kringelbach & Phillips, 2014). Intuition is not infallible, and sometimes when acted upon it can have a less than optimal outcome when used in less than optimal circumstances (Rosenberg & Gallo-Silver, 2011).

Howe (2013) implies that it is this understanding of the distress that a person is suffering that acts as a catalyst, a trigger which sets off a series of empathetic feelings which result in the manifestation of emotions. Therapeutic methods of communication, suggest McCabe and Timmins (2006) and Parker *et al.* (2007), result in personal interpretation that in turn provides a stimulus to base actions and holistic care upon (Tobin & Begley, 2008). Kohut (1977) and Howe (2013) have added that to understand another's suffering involves more than knowing just the primary cause: "we have to know so many other things besides what is seen and said" (Howe, 2013, p.101). This is in direct contrast to Smajdor's (2013) suggestion that care can be delivered without knowing the person. Both Kohut (1977) and Howe (2013) stipulate that to understand completely there is a need to know as much as possible about the person's attributes, their background, their history, what makes them unique and their personal identity. This enables two elements closely connected with empathy, "emotional resonance and cognitive understanding" (Howe, 2013, p.101), to become combined. In

combination these help provide the foundation for seeing the experiences of another from their perspective and enable compassion to be demonstrated. By knowing and interpreting fully what is being communicated, attuned action can lead to relieving the distress that is being personally experienced and witnessed. As Epstein and Street (2011) say:

Attunement also may have an important role in decision making and empathy; a sense of connection with trust can emerge during a discussion, for which none of the participants take full credit, that in turn promotes a stronger belief in and commitment to a treatment decision. (p.457)

Therefore, to be truly empathetic towards a patient there is a requirement to understand as completely as possible what the person is communicating of their experience. Immersion into their distress is required and, as a result, actions are required to ease the patient's distress and the personal distress suffered due to immersion. Reactions to distress not only help the patient, as the suffering is alleviated, but help the nurse in the knowledge that the suffering has been eased as much as possible.

If cognitive understanding (empathy) of a person's suffering is a requirement to trigger feelings which manifest in emotions and result in compassionate actions, this poses a question: if compassion is a cognitive entity, is it itself an emotion? Both Rogers (1975) and Nelson-Jones (1983) suggest that empathy has cognitive, behavioural and affective elements. These appear to be essential factors for empathy to occur: cognitive, thought processes which result in the ability to understand what another person is experiencing; behavioural, the ability to reflect or communicate the experiences of the person; and affective, the ability to feel what a person is experiencing (Somogyi, Buchko & Buchko, 2013).

It is appropriate to consider compassion from the perspective of attachment theory as it is thought that this theory of social development explains behaviour, relationship style and social competence throughout life. Attachment may affect a person's ability to feel and be empathetic, and therefore impact upon their ability to demonstrate compassion. Attachment theory was inspired by Bowlby (1969; 1973; 1980) who put forward the idea that attachment is based upon inherent human behaviours and emotions. Sable (2007, p.366) says Bowlby called upon the work of Darwin to

“understand the innate biases to our emotions” and to understand the distress that he witnessed when infants became separated from their primary caregiver. Bowlby thought that attachment behaviour and traits develop in early childhood and help survival of the vulnerable; their aim is to seek support and protection from an attachment or caregiving figure. Howe, Brandon, Hinings and Schofield (1999, p.22) expand on this by saying that the attachment traits that a person develops lead to “organised mental representations of self and others (as either positive or negative) that are carried forward by individuals and used to guide their behaviour in subsequent relationships” across life. This may result in a person who experiences a negative attachment experience as a child not being able to form a caregiving relationship in adulthood. The inability to form such relationships in adulthood can negatively impact upon the therapeutic relationships that are all important in the healthcare professions, as most care is based upon therapeutic relationships that develop between a patient and the healthcare worker.

Expanding upon these thoughts Bowlby (1969/1982), Kringelbach and Phillips (2014), and Bifulco and Thomas (2013) have said that It is not only the congenital genetics of a person that are instrumental in their ability to develop attachment traits throughout life; nurture and life experiences also have their place in shaping a person’s worldview. They all agree that a child can recover emotionally if they have been unfortunate enough to suffer emotional deprivation as a child. This appears to indicate that a person’s ability to attach or form relationships in adulthood is not purely dependent on their previous life experiences. However, a slightly different view is offered by Clarke and Clarke (1998), that “different processes may show different degrees of vulnerability to adversity, with cognitive the best buffered and emotional the least” (p.435). This indicates that emotional deprivation in childhood is the most difficult to recover from, and may continue to affect a person even if the person’s emotional circumstances change for the better.

Based on Bowlby’s work (1969/1973/1980) there are now recognised to be four attachment styles that people display in adulthood, based upon how comfortable a person is when faced with a situation requiring a close relationship (Sanford, 1997): secure, anxious, avoidant, and anxious-

avoidant. All but the first fall into the category of insecure styles, with people who have insecure traits finding it more difficult to form stable, emotional adult relationships (Mickelson, Kessler & Shaver, 1997; Bartholomew, Kwong, & Hart, 2001; Ainsworth, Blehar, Waters & Wall, 1978).

Khodabakhsh (2012) published his research into whether a nursing student's attachment style could predict how empathetic they would be towards patients, finding a direct positive correlation between a student nurse's secure attachment style and being more empathetic. Conversely, student nurses who demonstrated insecure attachment traits found it difficult to empathise or demonstrate empathy towards patients in their care, their difficulty increasing as security decreased. If empathy and being empathetic are directly related to the nurse's attachment style, then taking it one step further there could be similar links affecting other healthcare workers' roles supporting patients in therapeutic relationships. It could also mean that a patient's attachment style affects their ability to receive empathy; if so, the therapeutic relationship between the patient and healthcare worker may be affected.

There are strong connections between attachment theory and family systems theory (Bowen, 1978; Rothbaum, Rosen, Ujile & Uchida, 2002). Family, environmental factors, family dynamics and especially parental interactions are thought to be influential in a person's attachment development and the ability to love or feel for others that transfers into adulthood. Kerr (2000) refers to Bowen's (1978) family systems theory, noting that it is based upon the emotional systems that operate within families and directly affects an adult's ability to love and feel for others. This ability to be emotional with others outside of family develops from within their own family unit. Being emotionally demonstrative towards strangers is an important attribute for healthcare workers who daily meet strangers who need their help. Meiers (2015, p.165) says that personal experiences of family life "are powerful influences on perception, biases, and assumptions" which she directly relates to nurses' abilities to understand patients and form emotional and therapeutic relationships.

Comparisons have been made between attachment and family systems theories as both are concerned with the intimate relationships and dynamics

that occur within families, and both theories have similar classifications. Rothbaum *et al.* (2002, p.329) say that differences include attachment theory being based upon the influence that aspects such as protection, care and felt security have upon a child, while family systems are based on the dynamics and mechanisms operational within an adult family unit. Both theories have complementing and contrasting underpinning elements which have led them to be used in combination (Rothbaum, Rosen, Ujile & Uchida, 2002; Mikulincer, Shaver, Gillath, & Nitzberg, 2005).

Siegel (2007a) suggests that a person's experiences within their family and the attachment trait they have developed also influences an adult's ability to trust others, accept help and offer care; they are more able to form emotional adult relationships (Siegel, 2007a; 2007b; 2010). This is an important point as most healthcare workers, including student nurses, are adults. Siegel (2007a; 2010) uses the concept of attunement, examining the effects of relational associations that develop between adults that result in them feeling the same as each other. He suggests that emotionally attuned adult relationships have mutually beneficial results, and are crucial within relationships for people "to feel understood and feel at peace" (2007a, p.1). Attunement, which can occur throughout life, is a relationship between two or more people who connect emotionally, each experiencing feelings akin to love (Field, 1996; Siegel, 2007a; 2007b; 2010). These feelings are helpful in healthcare as if patients and healthcare workers are attuned to each other, this will contribute to a more harmonious therapeutic relationship.

There are also connections between attachment, family systems, attunement, love, trust and vulnerability. Baier (1986) states that "on first approximation, trust is accepted vulnerability to another's possible, but not expected, ill will towards one" (p.235). Trust is a principal inherent need within humans, as to be able to trust one another through interactions supports human beings like building blocks, enabling all parties to survive (Macmurray, 1961; Austin, 2005). Because trust enables survival, Erikson (1965) has suggested that within the very first year of life a child learns to trust or mistrust their main care provider, depending on the quality of their interactional experiences. This encourages reliance between people; however, trust is fragile and once broken it is hard if not impossible to re-

establish the trusting relationship. Breaking trust can activate the inherent emotions that support survival (Sellman, 2006). It is apparent to Peter and Morgan (2001) that a trusting relationship is not entered into without due consideration by the parties, as each risk exposing their vulnerabilities to the others. Because of this exposure, this vulnerability to self, there has to be sufficient justification to enter such a relationship.

Hendrick and Hendrick (2000), Sprecher and Regan (1998), and Sprecher and Fehr (2005) say that there are two types of love that emerge from the ability to attach to others in adulthood. One is romantic love that is experienced for a partner, and the other is compassionate love which can transcend to those outside such a relationship. The transition to compassionate love for patients is one that student nurses may be expected to demonstrate to patients in their care, as it is prosocial and an emotion directed from one person to another. The NMC (2013) has acknowledged that within nurse-patient interactions intimate but professional rapport, which includes confidences, may develop. This rapport may develop because of the patient and the nurse “sharing personal information, feelings and vulnerabilities” (NMC, 2013b, n.p.). Sprecher and Fehr (2006) also acknowledge the concept of “compassionate love” (p.227), but note that compassionate love felt for a relation or a person in a more intimate context results in a more intense emotion than that felt for a stranger in a caring situation. This closeness may be demonstrated through affection and kindness, and can have a soothing effect on adults when distressed (Gilbert, 2010; Cole-King & Gilbert, 2011).

The experience and demonstration of compassionate love benefits not only the recipients, but also those who provide it. These reciprocated benefits include the emotion of elation, and knowing that their efforts are appreciated (Sprecher & Fehr, 2006, p.233; Hatfield, Cacioppo, & Rapson, 1994; Keltner & Kring, 1998; Grant & Francesca, 2010). Underwood (2008), however, has described compassionate love as that which “centers on the good of the other” (p. 3), indicating that compassionate love may be reciprocal, but it benefits the person receiving it more than the person providing it. Molm (2010) has also put forward another form of reciprocal interaction, one that could be said to also reside within nursing. Molm (2010)

calls this form of interaction, when an individual gives help without knowing whether the other party will reciprocate (or be able to reciprocate), “reciprocal exchange” (p.119), noting that in some cases reciprocal exchanges are “without negotiation” (p.120). Applied to nursing, this is unusual as it is part of the NMC code of practice (NMC, 2015, section 2.5) for a nurse to respect the decision that a patient makes regarding their care and treatment, unless there is substantial evidence that the person lacks capacity to make such decisions (NMC, 2015, section 4.3)

3.3 Student nurses learning about emotions

For compassion to be present within a nursing context, cognitive awareness is required; this acts as a catalyst for emotions to manifest themselves. The stimulus for emotions appears to be feelings of empathy or attachment, and they appear to be a requirement, a pre-disposing factor if a patient is to receive compassion. Compassionate practice occurs because of an emotional experience, which when it influences a nurse cognitively results in behaviour that can be interpreted as an act of compassion. It is important here to consider that compassion is similar to empathy in that it is a cognitive thought process. These opposing thoughts lead to the suggestion that if compassion is an emotion in its own right, then this emotion is dependent on being activated through feelings, feelings that may be empathetic. If this is indeed correct, this will have an impact on endeavours to teach compassion, especially within the surroundings of a classroom, and leads to consideration of whether compassion can be taught.

3.4 Compassion in learning

Nussbaum (2001) and Newcomb (2007) are two educational theorists who support these ideas about emotion from different perspectives. Nussbaum (2001) defends the theory that emotions are a result of feelings and that judgements are made as a result of them. I have found, for instance, within nursing it is through the eight senses, the patient’s fear of suffering is perceived and the judgement is made that the person needs help. Like Nussbaum (2001) I suggest that judgements are personal, stemming from different factors such as personal beliefs, experiences and socialisation.

These judgement calls are a result of experiencing feelings or being empathetic towards someone: succinctly put, feelings that are perceived and cognitively activated stimulate emotions, one of which is compassion (Reich, 1989; von Dietze & Orb, 2000). In contrast Newcomb (2007), who bases his work on Arendt (cited in Newcomb, 2007), suggests that compassion occurs without rationality or judgement calls, and states, "Compassion is something that overcomes a person, so that one cannot choose to act with initiative and reason" (Newcomb, 2007, p.108). Both Nussbaum and Newcomb allude to compassion being an emotion; when I explore this idea further, I assume this means that compassion is an inherent human emotion that cannot be taught, but is activated through rationality, feelings or thoughts.

It appears that exposure to compassion-generating situations leads a nurse to experience feelings and emotions in reaction to the patient's distress. Through undergoing these experiences, nurses learn to control their feelings and emotions to reflect the professional persona expected of them: emotional labour occurs. If this is true, then the experiences by which a student nurse learns ideally should occur within an authentic setting. It is only there that a student nurse will encounter such emotional events in their entirety, the authenticity allowing the student to experience the control of their emotions and to demonstrate truly compassionate practice. An authentic setting refers to one where pedagogical techniques are employed to reflect 'learning by doing'. When applied to student nurses, this can occur within their clinical placements through practice learning or within the university setting. Within the university, authentic learning simulates how life exists beyond the classroom. It reflects the complexities of real life, as opposed to surface level and fact-based learning (Callison & Lamb, 2004)

It is important not to dismiss academic exploration of emotions and compassion through fact-based learning as futile. As Pence (1983) suggests, "Whether compassion can be taught depends in part on what we take it to be" (Pence, 1983, p. 189). Pence suggests that there are underlying ethical principles and virtues such as altruism, benevolence and social justice that, although not directly associated with compassion, can sometimes form a basis upon which judgements are based and compassion can emerge. For educators within the university sector, the thought that compassion can be

taught is firmly embedded within the curriculum (Wear & Zarconi, 2008), and compassion is directly approached in the NMC *Standards for pre-registration nursing*. Referring to curriculum content, these state:

Programme providers must ensure that programme content is applied within both a generic and field specific context enabling students to meet the essential and immediate needs of all people and the complex needs of people in their chosen field in relation to communication, compassion and dignity. (NMC, 2010, p.74).

To meet this standard, different methods are employed to enhance a student's compassionate learning experience, both enhancing their knowledge and enabling them to be more compassionate within their practice. This pedagogical effort to teach and instil compassion, which brings about compassionate care, is delivered via lectures or during skills practice when the phenomena of emotions are introduced and explored with students. Although it is impossible to replicate exactly the emotions that student nurses will experience within clinical practice, this will provide some understanding of the subject (Bray, O'Brien, Kirton, Zubairu & Christiansen, 2014).

Dewey (1938) put forward a theory that effective education and learning are based upon the experiences of the learner as they navigate the educational landscape, and saw the teacher's role as being facilitative to the student's learning. If learning is to occur, Dewey thought it important for the learner to be situated in realistic surroundings where the student leads the unfolding experiences in which they are immersed. Learning becomes student-led, based upon their experiences and not led by the beliefs that the teacher thinks the student should have. Role-play can be a good example of how students learn through their own experiences and contribute to the learning of others. Peters (2010, p.2) refers to Dewey's theory that students learn through their own experiences and contribute to the learning of others within the culture in which the learning occurs. Dewey also said that learning occurred through the senses, where learning is influenced by the setting in which the experience occurs.

Dewey (1933) was one of the first to write about the pedagogical influence of reflective practice, which has since become part of the learning

strategies of nurses in order to maintain high standards of education and evidence-based practice (NMC, 2010; 2015). Features of this model of reflective learning are its ability to optimise learning potential, change one's own behaviours and creatively find positive solutions to problems. Basing their work on Dewey (1933), Boud, Keogh and Walker (1983 p.19) suggest that emotions are involved as a person can "recapture their experience, think about it, mull it over and evaluate it". The emotional aspect adds another dimension to reflection as pedagogy, with the intention of it leading either to a fresh conception or greater understanding of the experience.

Schön (1983; 1987) contributes to the idea that reflection could be a method by which professionals learned through experience. He referred to the benefit of learning through reflection and promoted the principle of a 'reflective practitioner': learners who have ring-fenced time to think, revisit, and thoughtfully consider their own practices and experiences learn in a more philosophical way. He says that reflection is a skill that once mastered can be implemented both 'in' and 'on' action. Schön (1983, p.69) says that using reflection on action enables a person to explore past experiences, questioning not only personal practice but also the dynamics surrounding the situation. Reflection in action occurs when a practitioner is faced with a unique situation and draws on prior experience to solve the problem before them.

Supporting Dewey and Schön, Heyward (2010) concludes that role-play – a form of experiential learning which occurs in the interaction of the learner and others – has proved a positive method to increase the emotional understanding of students. This experiential interaction enables a student to learn in the relative safety of, for example, the university setting, as theories that underpin practice are introduced and the student is encouraged to act them out, reflecting in and on their own and others' actions as the scenarios unfold.

Babatsikou and Gerogianni (2012) say that this method of teaching gives students some insight into emotional experiences that are both shared and personal. It is possible to introduce scenarios based on authentic events that have occurred within practice (Slevin, 1999; Billings, 2012), and students are encouraged to take the part of actors within the scenario to explore what they

think, what actions they might take, and what their feelings and emotions would be. This method is not without its critics as it relies on the willingness of the student to participate and takes the use of imagination to be of value (Edmonds-Cady & Sosulski, 2012). Pence (1983) when referring to role-play as a method to teach compassion says, "The imagination then of ideal compassion is more than imaginative self-transposal, more than the Golden Rule of putting oneself in another's place" (p.189). He is referring to the individualistic nature of compassion and emotions, noting that imagining another's suffering may not reflect the true meaning that it has for them. Likewise, the very fact that it is a staged, synthesised exercise, using mannequins or other students to take significant parts within the unfolding scenario, raises questions of its worth in preparing the student for emotional experiences they will encounter within clinical practice.

On the other hand, the teaching of empathy has had better success as it has both affective (emotional) and cognitive (thinking) aspects which can be taught and learned (Clapper, 2010). Sheehan *et al.* (2013) support the teaching and learning of empathy as they write "The concept of empathy can be addressed and influenced by nurses in their role as educators" (p.457). In their systematic review of empathy education in nursing, Brunero, Lamont and Coates (2010) conclude that several pedagogical approaches, including role-play, experiential learning, self-reflection and journals, are of benefit when teaching and learning empathy. Ward, Cody, Schaal, & Hojat (2012, p.37), however, argue that there is a correlation between empathy and the student's amount of exposure to clinical practice: the empathy score was highest within the group of students who had the most clinical experience, and was significantly different from those with less exposure and experience within clinical placements.

There appears to be a vital link between the teaching and learning of compassion, based on the co-dependent nature of theory: it cannot be separated from authentic experience of dealing with emotions and empathy resulting from caring for patients. McCaugherty (1991) and Kolb (1984) have also indicated that theoretical principles that are taught can never reflect the experiences that students encounter within practice, but can give them an appreciation of what they might expect. This authentic experience of

compassion that results in 'knowing', with authentic surroundings and interactions with people, is acquired only within a clinical placement. This requirement explains the limited success of pedagogical efforts to teach compassion within the university environment. The teaching of empathy generally appears to have more value, as Hooks (2010) writes: "The interdependent nature of theory and fact coupled with the awareness that knowing is rooted in experience shapes what we value and as a consequence how we know what we know as well as how we use what we know" (p.185). This exemplifies the all-too-familiar divide between theories and their place within practice, or between "knowing how" and "knowing that" (Cope, Cuthbertson & Stoddart, 2000, p.850). It is one thing to understand how underpinning higher order knowledge and theories can support practice; it is another to transfer those theories into practical skills within one's practice.

3.5 Learning to be compassionate within clinical practice

I will now consider the teaching and learning that contributes to compassion within the practice placement arena, as this is where fifty percent of student nurse teaching and learning occurs (NMC, 2010). There is a long history of student nurses learning through experience within clinical practice placements, beginning with the apprentice nurses under the supervision of Florence Nightingale. Nurses learned to relate theory to practice within a situated learning environment and alongside more experienced nurses who would share their knowledge and experience. To illustrate this she writes in her book *Notes on Nursing* (1860):

The everyday management of a large ward, let alone of a hospital—the knowing what are the laws of life and death for men, and what the laws of health for wards— (and wards are healthy or unhealthy, mainly according to the knowledge or ignorance of the nurse)— are not these matters of sufficient importance and difficulty to require learning by experience and careful inquiry, just as much as any other art? (p.75)

The words of Nightingale still ring true today in the training of nurses, with the exception that the 'art' of nursing has developed and nursing is now a profession in its own right. During the lifetime of Florence Nightingale and beyond, medical doctors and their practices took professional precedence

over nursing staff. Nursing was viewed as supplementary to the medical model of diagnosis and cure. This has now changed, and nurses have been able to challenge this dominance as the nursing profession has developed a range of skills to contain and circumvent medical power (Wilmot, 2003). The changes have also affected how nurses learn within practice and the classroom; this is reflected in recent reforms to nurse education. With the launch of Project 2000 (UKCC, 1986), the importance of relating theory to clinical practice was officially recognised. It is thought so important that it is reiterated in the most recent standards for pre-registration nursing education, where standard six states: "Practice learning opportunities must be safe, effective, integral to the programme and appropriate to programme outcomes" (NMC, 2010).

The importance of higher order learning is explicit within the educational standards that influence student nurse training. It is also unmistakeable within the NMC document that experiential learning within clinical practice is thought to be crucial to skill acquisition. This coincides with the work of Dreyfus and Dreyfus (1986) and Berliner (1988) who affirm that experts within their fields function not only through higher order learning, but through having the ability to situate that knowledge appropriately within their practice. This ability, they suggest, has to be developed within authentic environments, and this has led to recognition that higher order learning along with situational understanding is the foundation of expert practice. Benner (2004) uses the Dreyfus model of skill acquisition in three studies that she conducted over a period of 21 years (p.188); she supports the importance of student nurses learning not only theory, but highlights the importance of articulation of that knowledge when it is applied to the learning of skills that student nurses acquire within authentic practice arenas. Reinforcing these thoughts in some detail, she refers to Aristotle, noting that nursing and practice involve a practical wisdom (known as "phronesis") and the ability to put this knowledge into action (known as "techné") (p.189). It is within clinical practice that a student nurse is offered opportunities that result in increasing levels of expertise by combining theory and practice, as "recognition of clinical situations moves from abstract textbook accounts of general features to an experience-based response to the situation" (p.190)

Both theory (academic learning) and practice (skill acquisition) are seen as being of equal value in the pre-registration programme: both are weighted equally and a student has to complete 2300 hours in practice and the same in academia to become eligible to enter onto the professional register (NMC, 2010). This ruling is to help ensure competence in trained nurses, who have higher order theoretical knowledge that can be demonstrated through acquisition of practical competencies. This method of teaching and learning has its critics: there are difficulties in making connections between the evidence-based theory that is taught within academia and the reality of practice (Kellehear, 2014; McEwen & Wills, 2014).

To help ensure that practice placements meet educational standards and are conducive to the facilitation of learning for student nurses, educational audits by HEIs are compulsory. Although undertaken by HEIs, these take a collaborative approach which involves the practice placement and forms an essential part of the assurance mechanisms to ensure a quality learning experience (NMC, 2010; Quality Assurance Agency [QAA], 2001; 2012). Generally, the audits look at the practice learning opportunities offered, help support and maintain the quality of the practice learning environment, and identify and promote inter-professional learning opportunities, but do not approach the question if the experiential learning is based upon a team or a community of practice (CoP) approach.

The difference between a team approach and a CoP approach impacts upon the learning of student nurses. The RCN (2014) uses the Salas, Dickenson, Converse, and Tannenbaum (1992) definition of team working as being “a distinguishable set of two or more people who interact, dynamically, interdependently and adaptively toward a common and valued goal/objective/mission, who have each been assigned specific roles or functions to perform” (p.4). Wenger and Traynor (2011) shed a different perspective on team working and define a team as “being held together by a task”, the task being the important feature as when the task is finished then the “team disperses” (n.p.). This could mean that if a team approach is adopted within practice, then practice itself is influenced and becomes controlled by the performing of tasks. When applied to nursing practice it may negatively affect care and therefore students’ learning, because by

adopting a stop/start task-oriented approach practice becomes non-fluent. As Benner, Tanner, and Chesla (2009) suggest, “Nursing, like other practice disciplines, is too complex and situated to be reduced to an ‘applied field’” (p.xiv). If applied to teaching and learning within clinical practice, and the method of care delivery is based upon task-oriented care, then this in itself can restrict learning outside one’s profession, as tasks become professionally based where learning, knowledge and practice are professionally bounded.

These two views of students’ learning within clinical practice are not new, though to date the NMC has not made it clear which approach should be adopted within the practice placement circuit to optimise student learning (NMC, 2008; 2008a; 2010). When the NMC emerged from the merging of the UKCC and the English National Board for Nursing (ENB) in 2002, it inherited a commissioned research project studying clinical judgement and nurse education. *Nursing identities and communities of practice* (Burkitt, Husband, MacKenzie, Torn & Crow, 2000) indicated that where CoP ideals had been adapted within practice, the “concept of ‘community of practice’ proved a powerful tool in aiding our understanding of how the learning of nursing skills and the development of a body of knowledge about nursing care is not simply an intellectual process” (Burkitt *et al.*, 2000, p.1). Among other pertinent points within the findings are the implication that CoP helped in nurturing and supporting students in ‘what’ and ‘how they know’, and specific reference is made to the support and learning that students’ encounter in situations which are emotionally charged and challenging (Burkitt *et al.*, 2000, p.1). In relation to dealing with emotions, they write positively about the value of COP and the support that comes from a multidisciplinary perspective: “this is often reflected in techniques for the management of emotion, especially in relation to the patients” (Burkitt *et al.*, 2000, p.3).

If student learning is improved by adopting the ethos of cross-disciplinary working that occurs in a CoP, then this approach appears to outweigh the benefits of working within an environment that uses teams. Within the nursing literature there is support for the implementation of CoP to enhance student nurses’ experiential learning (Burkitt *et al.*, 2000; NMC, 2010). Wenger (2008) says: “The health and social care field shows growing

awareness of the potential of Communities of Practice as an approach to learning” (p.vii). As the learning of empathy and its related aspects appear to be pre-requisites for demonstrating compassion, this substantiates the appropriateness of investigating in some detail the potential contribution of CoP to the facilitation of learning emotional and compassionate elements by student nurses. Wenger (1998) himself postulates that “the term practice is sometimes used as an antonym for theory” and that each of us may use these concepts developed from our backgrounds to influence our thoughts and behaviours. Within a CoP these different types of knowledge are intermingled and shared, resulting in CoP being “places where we develop, negotiate and share them” (p.48).

Positive aspects of CoP are that it is when a human being interacts socially with likeminded people that learning occurs and that everybody belongs to a CoP, whether in a professional or personal capacity (Lave & Wenger, 1991; Wenger, 1998, 2010; Brown & Duguid, 1991; Lesser & Storck, 2001). Wenger (1998) indicates this when he says that although members of a CoP are individuals with individual attributes, all the members have factors in common (p.45). These commonalities are instrumental, drawing them together into groups to work seamlessly, without barriers, for the common good of the community. CoP with their emergence through common interests are, as he says, based on “something they share, something that brings them together” (p.45). Gobbi (2009) echoes this when she writes, “Community members are therefore in communion with one another and are associated through fellowship, by practical transactions and by the way they act in relationship to one another” (p.71). This way of working could enhance compassion through mutual agreement that compassionate practice is a philosophy of the community. These views are not a completely new and build upon the work of, for example, Goode (1957) in his sociological examination of professions.

According to Wenger (1998, 2010), CoP can develop intentionally or evolve unintentionally, and being part of our everyday lives “they are so informal and pervasive that they rarely come into specific focus, but for the same reasons they are also quite familiar” (p.7). This can result in students not being cognitively aware that they are immersed within a CoP learning

environment within clinical practice, as “Most communities of practice do not have a name and do not issue membership cards” (p.7). This could mean that students, for differing reasons, may not know the concept of CoP or realise that they are situated within one, but this does not imply that they will not benefit from the CoP approach that they are situated within during their clinical placements. Wenger (1998) to support this writes, “a community of practice need not be reified as such in the discourse of its participants” (p.125).

Not all CoP are to the benefit of society as a whole. The word community conjures up an image of a place that is safe, enabling and nurturing, which may prove a stark contrast to what is actually occurring within them (Handley, Sturdy, Fincham & Clark, 2006). Wenger (1998) suggests that a CoP will reflect the social structures in which they are situated. He goes on to say that, a CoP is “a way of talking about the social configuration in which our enterprises are defined as worth pursuing and our participation is recognizable as competence” (p.5). CoP’s will not be beneficial if their structures are not robust enough to ensure associates’ continued membership or if the majority of society deems their practice unacceptable. This may occur where a CoP works in opposition to generally accepted morals, standards, practice or laws within wider society. Such CoP’s are considered unhelpful and may even become detrimental should they develop their own codes, methods and standards of working that cause harm both within the community and beyond.

Fortunately, a CoP operating in healthcare within the United Kingdom is governed by policies and closely monitored by external bodies to help ensure that required standards are met (NMC, 2008; Audit Commission, 2014; National Institute for Health and Clinical Excellence [NICE], 2015; CQC, 2015; National Service Frameworks, 2014). Though the system is not infallible, these policies and standards are subject to scrutiny and go through a democratic process before being verified.

An ideal CoP enables and values the nurturing aspect that such an environment permits. Wenger (1998) states that for members to get a clear understanding of each other that the process entails “negotiation of meaning, participation and reification” (p.49), negotiation referring to the

influence that members have upon the community and each other as they share information. Members are able to contribute and take responsibility for shaping the practices that are important within the community, through interaction or participation. Reification is helpful as it helps place artefacts such as guidelines, policies and procedures into context. This encourages students to learn in an environment which is both supportive and caring, while facilitating the synthesis of elements that contribute to learning within practice, compassionate practice being one (Soubhi *et al.*, 2010).

An important point that Wenger (1988) makes relates to what a person remembers most when they have been part of a CoP: “the people” (p.47). The people within the CoP are instrumental in making the learning experience for student nurses meaningful and purposeful. People within the community, including patients, can also have an influence on a person’s compassionate persona (le May 2009, p.15). However, as with any community, there will be individualistic power dynamics in operation, and these will influence the creation and dissemination of knowledge within it. Power influences the negotiated meaning within CoP as members have differing status and positions within the community. The power that a person holds can be down to personal expertise, the time that they have been a member or their personality, and may affect and limit the degree to which another community member participates and learns as they are the gatekeepers to learning experiences (May & Veitch, 1998; Yukl, 2006).

This is particularly relevant to the learning and participation of student nurses working within a CoP. The work of Lave (1998) brought to the forefront that students can be viewed as apprentices within practice learning. Starting from the periphery and working towards full participation within the CoP, they are dependent on the influences of the power hierarchy for their learning experiences. Using this approach, then due to their apprenticeship status students do not hold as much power, nor achieve the same full membership status, as members who are fully established and permanently working within the CoP. This is not to say that when students develop skills and knowledge that form part of the transition from apprentice to mastery, they do not become more powerful. By engaging in the present practice they also establish their own identity and contribute to their and the community’s

future (Lave and Wenger, 1991, p.113). Power may be attributed to the amount of training (experience) a student has undergone and is usually reflected proportionately in the responsibilities they are expected to undertake (Jewson, 2007).

The apprenticeship approach mirrors the view that Florence Nightingale took towards her new recruits in 1860 (Zurakowski, 2006). On opening her first nursing school she viewed her students as apprentices, there to learn skills to be utilised within the wards where they worked. This mode of learning dominated student nurses for approximately one hundred and forty years, up to the introduction of Project 2000 (UKCC, 1986; English National Board [ENB], 1996). One of the pertinent changes that occurred was due to the supposed tensions with viewing student nurses as apprentices and working within the apprenticeship model: students were not having their learning in practice optimised. This occurred as students had been counted in the numbers of rostered personnel and therefore expected to meet the needs of patients alongside the qualified staff; this meant that it was ultimately important to meet the needs of patients, and meeting the learning needs of the student was secondary (DH., 2012c). The amount that students contributed to hands-on care prior to the introduction of supernumerary status is evident in Moores and Moulton (1979), who estimated that seventy five percent of direct patient care was administered by students overseen by trained staff. To learn from a 'skilled master' is without doubt a good idea, and this continues to be so as each student on each practice placement is allocated a mentor who they are required to spend at least forty per cent of their time with (NMC, 2008a, section 2.1). With the introduction of protected supernumerary status, one of the flaws associated with the apprenticeship model was thought to have been addressed (English National Board, (ENB) 1996). This change has helped facilitate students to meet their individual learning needs, seeking out experiences to help fill gaps in their personal knowledge and practice, rather than the practice needs of the organisation to which they are allocated. In later reports and guidelines the UKCC (1999) and the NMC (2010) defended and upheld this stance, and the supernumerary status remains embedded within student nurses' practice (NMC, 2008a). However, Melia (2006) has raised concerns that the NHS is

predominately a workforce-led organisation that in some areas is poorly equipped to facilitate the meeting of learning needs, and learners suffer in the pursuit of meeting service requirements and required outcomes.

It therefore appears that the original apprenticeship model of Lave may be flawed within the current model followed in nurse education, except that Orr (1998) added to Lave's work from 1998. In his empirical work Orr (1998) extended the idea of apprenticeship and learning from skilled masters, to a more democratic view of communities where students could learn and participate while being active in developing knowledge and practices together with the trained staff. The approach adopted by Lave and Wenger in 1991 is more suited to the ethos of student nurses' learning and their supernumerary status within practice. Lave and Wenger (1991) refer to this multifaceted give-and-take entwining relationship between practice and participation as "mutually constitutive" (p.117).

3.6 Summary of chapter 3

The themes that emerged from the literature review that formed the theoretical framework for my study have been previously discussed in chapter two. Two main themes and four sub-themes materialised. Theme one was the emotional dimension to compassion and its sub-themes were attachment and emotional labour. The second theme that emerged comprised the pedagogical approaches employed to teach and the effectiveness of learning compassion. The teaching and learning of compassion included the use of role-play which transcended university learning spaces into situated learning within clinical placements. There was particular reference to clinical environments whose ethos primarily takes a CoP approach.

Chapter 4: Methodological Considerations

4.1 Introduction

For the purpose of my study I define 'methodologies' as philosophical frameworks that guide my methods; methods being means of data collection, analysis and synthesis (Freshwater & Cahill, 2014, p.35). The personal and complex perceptions of the students presented through case studies were imperative in this research. Within the study, I employed ethnographic techniques and narrative which I chose particularly to address the research questions as this approach would let me explore the culture in which the students are immersed. I wanted to explore their personal ideas and perceptions, and the influences that impacted upon them as they learned and demonstrated compassion in university and clinical settings. I employed case study as a method to present the stories that the students tell, as this would allow me to present an individual analysis of each student's narrative as well as those of the group. I could look across the cases to locate and unravel themes that were common, and those that were unique within the trio (Merriam, 2009).

The main advantage to adopting both ethnographic and narrative approaches is that in the context of my research each complements the other. Narrative, like ethnography, is an interpretive approach. To utilise narrative methodology effectively involves participants telling their stories through an ethnographic approach. I am already part of their culture which helps me to interpret the meaning of their narratives. The language that the students use to tell their stories is particular to them as a group and constructs the culture in which they operate (Creswell, 2007). Using both methodologies results in a stronger research design, and in more valid and reliable findings from my study of the individual and collective perceptions of the students (Mitchell & Egudo, 2003).

Below I will expand upon and justify the research endeavour that went into the planning of my study. I begin by discussing the important part that reflexivity played in situating my reflective self within the study. I discuss why I chose an ethnographic and narrative stance and selected to present the students' stories through case studies. I also include overviews of ethical

considerations, the selection of participants, the approach I use for data collection and my approach to the analysis of the data.

4.2 Reflexivity

I am aware that being the reflexive person I am benefits my study. Pillow (2003, p.178) has said that to be reflexive “not only contributes to producing knowledge that aids in understanding and gaining insight into the workings of our social world but also provides insight on how this knowledge is produced”. As the researcher, being continually reflexive helped reduce my biasing effect on the students and the research process (Davies, 2002)

I have alluded to the impact that my first experience of compassion had upon me as a student nurse, one that has lasted throughout my personal and professional life. Reflexivity requires that I expand on my current position within the research. I have no doubt that I have my own perceptions and multiple realities of compassion. These perceptions and realities have been formed over a total of thirty years and come from the perspective of being a student nurse, a qualified nurse and currently as a nurse educator for the last fifteen years. I can say I know and understand what my perception of compassion is, but I do not know what the students' perceptions of compassion are. Reflexivity requires that I acknowledge that my realities may affect the research as I look into the perceptions that my own students have. Their perception of compassion may well be influenced through their educational experiences as student nurses; educational experiences that I have contributed to.

My interface with the students past and present, and in the future, raises a particular concern for me. I am in a position of power in relation to the students; I have taught them in the past and have had a direct impact on their learning. This raised ethical considerations. I needed to manage the power imbalance between the students and me if I was to minimise harm to both the students and the research process. One way was to work with the students using reflexivity to analyse any impact I may have had upon them. Even then I would not be able to remove the power imbalance completely, as I will always be in authority as their nurse educator (Clough, 2002; Clough & Nutbrown, 2007). It was a conscious decision that I took to work together

with the students rather than to make them an object of my research. I took into account what Wasserfall (1997) said:

The use of reflexivity during fieldwork can mute the distance and alienation built into conventional notions of “objectivity” or objectifying those who are studied. The research process becomes more mutual, as a strategy to deconstruct the author’s authority. (p.152)

Taking into account Wasserfall’s comments, the interviews were driven by the students’ experiences and thoughts, which they all readily wanted to share with me. I was privileged that they trusted me and they appeared to appreciate the opportunity to tell me in their own words their innermost thoughts of what compassion meant to them. The power imbalance appeared to be addressed as each of the students directed the path that the interview took.

This was helped by the environment that the interviews were carried out in, which Tracy (2012) has said can adversely or positively affect the interview process. Therefore, I purposefully conducted the interviews in a neutral environment that was away from the learning, teaching and practice environments. I thought that a private, yet comfortably furnished room that was known to the students would be ideal to carry out the interviews. Before making my final decision I asked the students for their opinion of the choice of venue. All agreed that my choice was suitable. This venue had the desired effect as they appeared relaxed and spoke freely about their experiences.

Being reflexive and keeping my comments within the interviews to a minimum helped ensure that they told their stories in the manner that they wanted and in a language common to their cultural circle. I adopted Spradley’s (1979) approach to ethnographic interviews by informing the students of the explicit purpose of our meeting, and this helped to minimise my influence on the stories they told. I included three types of question to gather their perceptions: descriptive, structural and contrasting. Examples of descriptive questions include “Could you tell me what compassion means to you?” and “Could you describe what you felt?” Examples of structural questions include “Can you think of what has helped your learning around compassion” or “What has impacted upon your perception of compassion within your training?” Contrasting questions included “What is the difference

between learning about compassion in practice or within university?” and “How do different approaches to your learning effect your understanding of compassion?” This approach to interviewing the students added meaning to the stories they wanted to tell and not stories that they thought I wanted to hear. However, even applying this ethos to the interviews may still not have been enough to remove the influence of my status as their teacher and their disclosures could still have been biased or distorted to appease my interests (Weiss & Fine, 2000).

To help minimise the effect that my influence may have I found the work of Denzin & Lincoln (2005) helpful as they indicate that what is important is the concept of representation. In seeking to understand the worldview of the students, it is impossible for me to comprehend their position fully. The best I can hope to achieve is to represent them as faithfully as possible. Pillow’s (2010) reflexive framework was utilised throughout this study to understand the influence I exert over the collection, analysis and presentation of data, as well as analyse the relationship I have with the participants. Pillow indicates that reflexivity is a methodological tool to analyse the process of representation, and emphasises the need to reflect upon the ways in which my own values, beliefs, and interests can influence my ability to represent the data.

Within the research I continually reflected on my experiences as an educator, researcher and nurse. When the students told me about some of their perceptions, some of the things that they said resonated with my experiences. It was strange as I distanced myself and took the view of an observer looking through into the world of the students’ perceptions. It was trying to look at what they said through their lens, not mine, that helped distance me from my educational and nursing roles. Reflexivity became a principle to help validate my study as it was by being reflexive that I was able to make sense of the research process and the contribution that the students made. Reflexivity also complements the ethnographic approach I took as I viewed the students as the experts, the source of knowledge from which I could learn. I experienced their beliefs, which became the basis for sharing their information as I viewed their world through an ethnographic lens (Etherington, 2004; Wasserfall, 1997).

4.3 Ethnography

Qualitative research forms the foundation of my study, and it is through an ethnographic lens that I can unpick and interpret the stories that the students wanted to tell me in the way that they wanted me to hear and understand them. It enables me to discover their culture and delve into their world to see and understand their experiences and beliefs. Unpicking and interpreting the meaning of the stories are based upon being reflexive on my previous experiences. This enabled me to represent the voices of student nurses from emic and etic perspectives (Creswell, 2007). I investigated what was important to the students, their thoughts, words and how they perceived the culture in which they operated. I let their words tell their stories and allowed them to direct the themes that emerged, trying to put aside my assumptions (Lett, 1990). Equally, I was able to achieve an etic or personal perspective based on my previous experiences, and by applying theories and reporting on what they said within their narratives (Morris, Leung, Ames, & Lickel, 1999). As Fetterman (1989, p. 11) says, "The ethnographer enters the field with an open mind, not an empty head." This approach helped give me a rounded view of what my group of students said and I could relate their perceptions to the larger milieu in which they operated.

Geertz (1973a, p10) says that to carry out an ethnographic study involves gathering thick and rich descriptions of the participants' thoughts, beliefs, society and culture in their natural setting. Each of my participating students is unique with individual thoughts, but I can determine their perception(s) of compassion and interpret their distinctive and personal meaning by studying their responses. I have established that it is impossible for me to be completely neutral as I am integral to the research process: the researcher significantly "contributes to the construction of meaning" (Gilbert, 2008, p.512). I agree with Gilbert as my research was dependent on my interpretation of the unfolding data that the students supplied. Without my insight into their perceptions, the data would literally be pages of interview transcripts.

It is usual for ethnographers to spend the working day with the participants of the study. As I am a nurse educator, I am in the privileged

position of being immersed every working day within the culture that the student nurses find themselves in. I am also instrumental to their learning, and share experiences within both the university and clinical settings. For example, I have regular contact with the students within lectures where I use multiple pedagogical approaches to underpin their theoretical knowledge of nursing. I am involved in the teaching of clinical skills and role-play to help prepare students with theoretical and experiential knowledge and competencies before they go into practice. Most times I could describe my contact with the students as shared learning: as I encourage them to actively participate within the lessons, it can be a two-way process where we not only teach but learn from each other. I also regularly go into practice placements, to offer support and discuss the positives and challenges that the students are experiencing.

Therefore, I am subsumed in the students' world and culture because I operate alongside them within university learning spaces and clinical practice. This contact helped me to represent the students' views from their point of view (Wolcott, 1999). The active participatory role of ethnographer let me focus, interpret and describe the emerging data that the students provided. I could investigate and interpret their shared culture – a culture unique to student nurses – their patterns of beliefs, their behaviours and language. In my study, I let the students' metaphors drive the direction of my ethnographic stance; my contribution is subtle, and I am careful not to overpower their voices (Denzin & Lincoln, 2011).

4.4 Narrative

From the inception of my study, I established that there is a lack of students' voices on how they perceive compassion. Narrative provided a system of gathering information that enabled me to focus upon the meaning that the students attributed to their experiences, and on how their experiences contributed to their personal perception of compassion. Josselson (2006, p.4) says that narrative inquiry provides "insight that (befits) the complexity of human lives" and it was the complexities of the students' lives that I investigated.

The narrative methodology emphasises the importance of hearing the voices of the students, as they are the ones who every day encounter the notion of compassion. It was through “radical listening” (Clough & Nutbrown, 2007, p.15) that I purposefully focused upon them: I concentrated and heard the intent of what they said, as they told me their stories and as they produced, represented and contextualised their experiences and personal knowledge. Stories represent a genre within narrative that recounts the characters involved, the events, the complications and consequences of what unfolded during their experiences. As well as telling their stories to me, they also told their stories to themselves. They recalled the stories that were important for them to tell, and these evoked memories which they synthesised and imposed meaning upon.

Using a narrative approach also enabled me to look critically at the way the students constructed their stories as they drew upon experiences from within their culture. Clandinin and Connelly (2000, p. 20) say that narratives are a “collaboration between researcher and participants, over time, in a place or series of places, and in social interaction with milieus”. When employing this narrative interview approach I was mindful not to fracture the narratives, and therefore not remove their uniqueness which Riessman (1993, p.2) says characterises narrative accounts.

These commonplace dimensions associated with narrative inquiry helped me to highlight factors that had impacted upon the students’ views: for example, the effect that experiences had upon the students over time; and the effects of the cultural influences that operate from birth and importantly allow the existence of a common ground, the place in which they are now culturally positioned as student nurses within the pre-registration programme (Connelly & Clandinin, 2006).

This method of recording the students’ metaphors also sits comfortably with an ethnographic approach: as Geertz (1973a, 1973b) says, the culture of people can be investigated through the language they use that is unique to them. It enables the listener to gain insight into their world and make sense, interpret and understand. Therefore, narrative, like ethnographic methodology, allowed me to take emic and etic perspectives as I unpicked and moved between the tiers of meaning. I was able to interpret the

metaphors to represent the students' perceptions while critiquing them, and that allowed me to give my interpretation of what they said and how they said it (Keesing, 1987, p.166; Fetterman, 1989)..

With these reflections on the use of reflexivity, the integration of ethnography and narratives complete, I can now purposefully discuss the use of the methods I employed to contextualise, analyse and validate the research process and my findings.

4.5 Sampling procedure

I utilised purposeful sampling with a cohort in their final year, where all were completing the last modules of the programme including pedagogical and clinical practice. I did this as by then they had the maximum experience of learning compassion within the university study spaces and clinical practice before they became qualified professionals. Purposeful sampling was appropriate as it meant that I could select participants who, according to Creswell (2007, p.125), could consciously and knowingly understand the research problem and contribute appropriately to the journey of discovery. Purposeful sampling entails that I know the participants and that according to my judgement they would produce the best and most valuable information that I needed for my study. I had knowledge of all the individuals in the cohort, and the opportunity to be a participant in the study was open to all.

My study focused on three main participants. I recruited six willing and consenting students to be part of the study; but on analysing the data, only three of the interviews had generated the insight into compassion that I sought. The students whose data I was able to use demonstrated commonalities that were apparent within the interviews. All appeared relaxed, spoke openly and honestly, and efficiently focused their narratives about their experiences, beliefs and behaviours, so revealing what they thought contributed to their perceptions of compassion. They needed little or no prompting, and apparently felt no awkwardness throughout the interviews. The data from my other three students proved less suitable when I transcribed it. One of my participating students had recently become a student ambassador and focused upon the responsibilities of that role; one student stopped her interaction with me after a few minutes and, despite

coaxing, proved not to be articulate and became so embarrassed that I stopped the interview to prevent harm; the third student spoke about their last employment and did not focus on their perception of compassion as a student nurse.

This “big net approach” (Fetterman, 1989, p.32) that I took by interviewing six students allowed me to get data from all of my participants and then focus upon those students who provided the data pertinent to my study. A small sample size is also suitable for my study as it is qualitative research which utilises semi-structured interviews to collect the stories the students tell (Miles & Huberman, 1994), This approach to purposeful sampling and the information that the data revealed fulfilled the criteria and provided me with the information that I sought to produce case studies.

4.6 Case study as a method

The three embedded case studies (Yin, 2004) were chosen to particularly meet the needs of the study and construct meanings of compassion from these individual perceptions (Stake, 2005). This approach allowed each student to tell their stories individually without fear of interruption or judgement from others. The time that I spent with Kat, Elizabeth and David was their time and I did not put a time limit on their individual interviews. This was to allow them to tell me their experiences at their own pace in their own unique way which was fundamental to the cases.

These case studies can also be deemed as collective as they emerge from a group of nursing students chosen for their similarities: they are situated in the same cohort, they had been taught using the same curriculum, and they had experienced similar clinical practice. The differences between my student sample included individual attributes such as gender, age and the effect of their previous experiences. This collective approach allowed me to make comparisons and expose differences from their emerging perceptions, which manifested into some common themes and also uncovered some that were unique.

According to Merriam (2009) and Stake (1995), the case study approach lies within the constructivist paradigm, which reflects my ontology as I believe that perceptions are constructed through knowledge and experience. Case

study has sometimes been described as a methodology in its own right (Yin, 2009), but I use case studies as a method (Dyer & Wilkins, 1991; Merriam 2009). Case studies are popular in the context of healthcare and education, as they can be utilised to study the experiences of people and disseminate knowledge within both the healthcare and education systems (Lovell, 2014; Merriam, 2009). I use multiple case studies as a method to represent metaphors used by the students to express their perceptions of compassion, as they allow me to capture the complexities of the phenomenon. Each individual case study is inherently valuable, but multiple case studies and cross-case analysis allow me to produce knowledge that is more generalisable across the context. I was able to combine Spradley's (1979, p.49) approach to ethnographic interviewing which provides structure, with Simons' (2009, p.47-48) process of in-depth interview approach which she says is helpful in gaining data for case studies. Both approaches use descriptive questioning, often using 'how' and 'what' questions to get the views of the participants. This helped me to increase the validity of the analysis and synthesise differences and patterns that emerged.

Case studies are by their nature qualitative and are "inherently multi method" (Denzin & Lincoln, 2011, p.5). Stake (1995, pp.xi-xii) says they enable the researcher to draw together "a palette" of methodologies such as those that I have described. Case studies give credence to me using the narratives of the students as they tell their stories, their perceptions of compassion. The students' voices reflect their personal thoughts in their own words, powerful, raw and rich in data. I collected data through in-depth semi-structured interviews; any other method would have not been applicable, as it would not consist exclusively of narratives. I could analyse their meaning using my experience from an ethnographic perspective, since according to Fetterman (1989, p.50) "Ethnographers use interviews to help classify and organize an individual's perception of reality."

4.7 Data collection

I used the data collection framework offered by Silverman (2006, p.67) as it features looking, listening, recording and asking as methods. Thus, I could use interactional semi-structured interviews to collect data (Barriball & White,

1994), audio recording the students' responses which in turn allowed me to personally transcribe verbatim what they had said. This was important to the way I wished to pursue my study as it enabled me to become intertwined within the emerging data. I got to know what they said and what they meant. I could appreciate the emphasis that they put on the language they used, and the emotion and the culture that they experienced, as they metaphorically transported me to different domains of learning and to places where their experiences and perceptions of compassion were formed. The interviews took place over a few days in a university setting in a private, quiet room

The cases that I present are instrumental in nature, gathering evidence that can "provide insight into an issue" (Stake, 1995 p.445). This insight was gained through conversations with Kat, Elizabeth and David taking the lead, directing the conversation at a pace comfortable to them. They spoke to me clearly and deliberately, and I listened to them intently, noting every inflection so as not to misinterpret their meaning but to understand the essence of what they wanted me to hear and understand. Some of the time what they said appeared to be emotionally challenging, yet when given the opportunity to stop the interview, it was so important to them to tell me that they opted to continue. Sometimes they would repeat a word or sentence to emphasise the importance of the point made. Telling me what was important to them was in itself humbling, showing they trusted me implicitly as they revealed their insights into what compassion meant to them.

4.8 Data analysis

I decided to use ethnographic content analysis (ECA) (Glaser and Strauss, 2009) to understand and unpick the meaning of the students' narratives. This approach suited my research as ECA relies on the researcher applying reflexivity and is collaborative in nature: I wanted to work with the students to portray what they said was important to them and how they said it. Using ECA allowed me to be central to analysing the data, taking account of how the students told their nuanced stories and understanding the context in which they related their experiences. It enabled me to unpick their stories

and remain connected; and consequently I could reveal themes and relate them to relevant theories to verify and make sense of what they said.

ECA relies on the documentation and understanding of communication. Listening to the students' narratives, I found I could move easily between their stories, interpreting and analysing them, repeatedly returning to them to ensure that I was understanding and as accurately as possible portraying what was important to the students. By drawing upon their narratives, I was able to allow them to guide and influence the emerging themes, rather than me placing what they said into predetermined categories. ECA allowed me to use each student's individual perceptions of compassion and repeatedly check what emerged against the relevant theories, to develop an analytical construct. Each case that emerged was personal to each of them, yet produced themes that were both common and unique within the cases (Altheide, 1987).

4.9 Ethical considerations

Prior to the commencement of the study I applied for and gained ethical approval from the university in which I was to carry out my research. The starting point was to uphold the major ethical principles of beneficence, respect for autonomy, non-maleficence, utility and justice (Beauchamp & Childress, 1994; British Educational Research Association, [BERA], 2012). Signed consent was sought via paperwork that laid out all the details of the study and supported the underpinning ethical principles. This stated that the participants were able to leave the study without prejudice at any time, and those recruited also received a copy for their personal reference. The rights of the participants were respected throughout the study, and their autonomy was upheld as participation was based upon informed consent.

I was particularly sensitive to the fact that I was known to the participants and had to avoid the risk of any of the students feeling coerced or threatened because of my position (Beauchamp & Childress, 1994). I went some way to address this by inviting the entire cohort to participate in the study and waiting for responses. I then contacted the students who responded with further details of the study. I arranged the interviews around their availability, as I wanted them to feel as comfortable and undistracted as possible.

Reflexivity helped address the power imbalance along with my ethical position of doing no harm to the students. Even with this made explicit to the students, the perceived power imbalance may have affected their disclosures; it is difficult to know if their stories were told in a manner that was biased to appease my interests (Cresswell, 2014).

As the researcher, I was aware of the sensitive nature of the subject. Qualitative research is by its very essence sensitive, exploring a person's innermost thoughts and feelings, which might be emotionally challenging for the students and me (Parahoo, 2006). With this in mind I put into place support mechanisms, which included the university's counselling service. I also made contact with each of the students the day and the week after their interviews to help ensure their wellbeing.

To protect the identity of Kat, Elizabeth and David, I asked them to choose their own pseudonyms as I thought that this would make their stories more personal to them. The stories that they told me were processed confidentially, and data was not shared or stored in a way that compromised the identity of the students or the information that they had given me (Polit and Beck, 2010; BERA, 2012). To ensure this all data was stored in compliance with the Data Protection Act (1998).

4.10 Summary of chapter 4

In this chapter I examined the use of reflexivity and highlighted my reflexive self as I situated myself within the research. I went on to discuss my rationale for using ethnography and narrative as methodological approaches best suited to answering my research questions. These qualitative approaches allowed me to interpret the narratives of my participants, yet incorporate my prior experiences and understanding within the context that I was investigating. I described how I arrived at the decision to use case study as a method: it would allow me to analyse and present the narratives of the students individually and across the cases. I included how I used purposeful sampling to recruit my participants. Finally I considered the ethical considerations as I wanted no harm to occur to my participants.

In chapters 5, 6 and 7 I present each of the case studies, before presenting my critical reflections on the findings across the cases in chapter 8.

Chapter 5: Kat's Story

5.1 A personal introduction to Kat

I first met Kat at the very beginning of the programme when I was allocated as her personal academic tutor (PAT), and this relationship was to continue for over twelve months; then the PAT list was reshuffled and Kat was allocated to another. Therefore, although I had a very close relationship with her for twelve months, that link was severed after she was reallocated. The contact that we had after that occurred informally on corridors or within classrooms and clinical practice.

Kat came to England from an Eastern European country about five years ago. She came with her husband and very small baby “to have a better life, to make something of ourselves and to give our baby chances that we didn't have before”. English is Kat's second language and she made me aware how challenging it has been for her to adapt to English conventions in speaking and writing, particularly for academic purposes. Kat has overcome this and successfully gained a place on the programme leading to the qualification of adult registered nurse, and is proving herself to be a conscientious student both academically and clinically.

5.2 Kat's definition of compassion

When asked how she would describe compassion Kat began by saying:

I think that's really hard to describe what compassion is. I just think it's the way you act when you see suffering, I think that involves emotion. It's always about suffering, it is always about when I see somebody who suffers, the feelings that I get, I want to help, it's about help, for example when I see somebody's suffering I wish I could do magic, make them feel better. I think it is an attitude somebody has towards to somebody who is suffering. This attitude is like feeling what they are experiencing, it's like, because I know I can't experience exactly the same as they are feeling, sometimes though I do think it hurts me as well, I get like a physical pain, sometimes it makes me feel ill, I if I can stop them suffering my pain goes too, I feel better. I don't know whether I have made myself clear, that I just think that it's the way you act, attitudes, feelings, understanding and emotions.

Initially Kat says that she finds it difficult to describe what compassion means to her, although she quickly associates compassion with suffering. Kat says

that seeing a person who is suffering has an emotional effect upon her that results in her trying to help the person. Tortora and Derrickson (2009) and Plutchik (2001, 2002) note in their acknowledgements that distressing encounters between people evoke physical sensations that are activated as part of an emotional response to sensory perceptions. Kat is very definite when she uses the word “*suffering*”, and repeats the word a number of times as if to help her describe the extent of the anguish a person she cares for could experience.

The word ‘suffering’ in itself is emotive and conjures up resonances of extreme pain, anguish, misery, agony, torment and distress. Plutchik (2002, p.103) refers to the “language of emotions” and argues that some words used to describe an emotion represent the intensity of the emotion that a person experiences. Kat perceives that a patient in her care is suffering, she witnesses anguish and this initiates a physiological response. This in turn results in an emotional response that prompts Kat to want to alleviate the suffering that she is witness to. Kat’s thoughts are supported by Lazarus (1991, p.289) who writes about a person witnessing suffering: the emotion(s) that transpire result in compassionate acts to relieve the suffering. He also suggests that compassion is a direct emotional response to what a person witnesses, and not an unequivocal and direct result of what the person perceives the distressed person to be feeling. Lazarus, along with Nussbaum (1996; 2001), confirms that self-preservation also stimulates an emotional response: as Kat says, “*I get like a physical pain.*” This desire to preserve oneself from emotional harm leads to compassionate actions and the wish to alleviate the “suffering and wanting to help” (Lazarus, 1991 p.289). Relieving the suffering of the person also appears to be helpful to Kat personally: as she says, “*if I can stop them suffering my pain goes too*”. She appears to identify with the suffering of patients in her care and experiences emotional lability alongside them, feeling emotional pain which appears to be synchronised to the patient’s pain, so that if she relieves the pain of her patient then her emotional pain is relieved (Benner, 1982: Hochschild, 1983).

Kat employs the word “see” and refers to the sense of sight in her description of how she recognises when a person needs compassionate help. These confrontations result in emotional and ensuing reactions when

she witnesses anguish, or as she says *"I see somebody suffering"*. It is these experiences of perceiving another person's anguish through sight (and probably other unmentioned senses as well) which, she indicates, result in an inherent and uncontrollable emotional response which leads her to want to undertake actions to alleviate the distress that a person is enduring. Reaction to events that Kat witnesses results in her taking positive measures to help the person, but in doing so she is also helping herself. Howe (2013) has commented on how taking positive measures to relieve the distress of another also helps the rescuer as it relieves the distress that they are immersed within. Kat is agreeing with Howe: as she says, if the person's suffering is alleviated, she too feels a sense of relief.

Kat then expands on this theme, relating to attitude and the part that attitudes play not only in the interaction between patients and nurses, but in the forming of personal emotions. Kat says that sometimes her attitude to patients can result in experiences so intense they can manifest as physical and personal pain. This response is linked to the Schachter-Singer theory (1962) and their suggestion that emotions can have both physiological and cognitive impacts that can manifest in the person and be described as painful. Schachter and Singer (1962) believe that emotions occur as a result of experiencing differing eliciting stimuli received through the senses. Emotion becomes a cognitive response that requires a person to interpret both what they perceive through the senses and their physiological changes. This 'two factor theory of emotion' (Schachter & Singer, 1962) states that the person has to witness an event (factor one) that initiates a psychological response (factor two). It appears that Kat is experiencing both, which could account for her perceiving an emotional experience as a vicarious feeling and then misinterpreting and describing the emotional experience as physiologically painful.

The feeling of pain that she relates to here could also signify that Kat is feeling empathy or being empathetic. Stebnicki (2007) suggests that a person can become so subsumed in another's suffering that they view it as their own. This appears to be what Kat is experiencing as she indicates that she is experiencing intense emotional distress because of her interaction with the person who is suffering, which is resulting in the manifestation of

stress that she interprets as physical pain (Sheehan *et al.*, 2013). In their references to empathy Rogers (1957; 1975), Nelson-Jones (1983), and Somogyi *et al.* (2013) believe that being empathetic requires a person to experience what the other is feeling. The intensity and far-reaching effects of emotional pain can be illustrated when reactions to it manifest as physiological changes in the body. Although conscious thought can enable rationalisation that it is emotional distress that is occurring, this sometimes does not prevent manifestations of adverse physical and psychological reactions (Kassam & Mendes, 2013).

The feelings that Kat says she is experiencing are akin to post-traumatic stress disorder (PTSD). Though PTSD is controversial, in that some professionals challenge whether this syndrome actually exists and what confirms its diagnosis (Mason & Rowlands, 1997, p.387), this disorder may explain the manifestations that exposure to distressing situations bring over time. It can also be associated with how Kat describes the emotional challenges she faces, saying she experiences pain similar to the patients' (*"like feeling what they [the patients] are experiencing"*). Burkitt (1997, 2002) suggests that this condition manifests in people who have witnessed or been part of distressing happenings; again, although it is emotional distress it can result in both psychological and physical illnesses. Burkitt goes on to imply that a person's health can suffer when they engage in tasks that they find stressful, but are expected from a social perspective to do as part of their job role. Kat implies that her health is suffering as she says, *"sometimes though I do think it hurts me as well"*. Mason and Rowlands (1997, p.387) also suggest that PTSD can develop due to contact with a stressor. Stressors may involve the witnessing of distressing situations, pain and suffering, and actual or threatened death or serious injury (p.387). Kat is coming into contact with stressors in her situation as a student nurse: she is witnessing distress while having to care for and interact with a person suffering, and this appears to be negatively affecting her wellbeing (*"it makes me feel ill"*).

She continued to relate to the emotion of distress, exhibiting what may be described as desperation resulting from stress and anxiety; the pain of others is making her feel ill. She refers to witnessing suffering and wishes to rid the person of this state very quickly as there is an urgency in what she says. The

complexity of compassion can be seen in a brief but moving acknowledgement from Kat: *"I wish I could do magic."* As Benner (1982) contends when referring to the emotional challenges that student nurses face, she wants to remove the distress that the person is feeling, but is also aware that an instantaneous solution to abate the suffering is not always available. There appears to be a dual imperative in that protection of the patient and herself are in play. Kat's desire to interrupt the patient's distress is paramount, alongside, if a little less important, the need for self-preservation (Hochschild, 1983; Tracy, 2005). Kat has previously expressed that sometimes the psychological emotion she feels for her patients in distress can be painful, and says it sometimes feels like or manifests as a physical pain: *"I get like a physical pain, sometimes it makes me feel ill"*. Compassion in this sense appears to have symbiotic qualities: if Kat helps somebody through her compassionate actions, then she also helps herself – she minimises harm to her patient and herself (*"I feel better"*) (Hochschild, 1983).

At the very end of this part of her account, as if to distance herself from the emotional turmoil that she sometimes feels, she takes herself out of the story, removing herself marginally as she begins to talk in the second person (*"I just think that it's the way you act."*) Up to the final sentence she uses the word *"I"* to relate the experiences and the opinions that she has to herself. She then converts to using *"you"*, as a trajectory suggesting that compassion is an approach that *"you"* have towards another person in need. This is a form of psychological distancing in which individuals avoid introspection by speaking in the third person (Kross, Ayduk & Mischel, 2005). Kat uses the third person approach as she is relating past emotional and hurtful memories, and she may be removing herself slightly into the relative safety of the third person and away from past memories that she finds emotionally challenging. This subtle removal into a passive position contests the theories of empathy, which are thought to be a precursor to emotional events. Being able to empathise, according to Baillie (2005), enables a nurse to meet the holistic needs of a patient. For these needs to be met, according to Stebnicki (2007), requires a person to become immersed in what another person is feeling.

5.3 Reciprocity

However, in the next part of the interview Kat alludes to times that she is not completely immersed within the suffering of patients, and therefore may not be fully empathetic with their situation (Beddoe & Murphy 2004, Stebnicki, 2007). Kat went on to describe that she has found that there are some barriers to eliciting compassion.

I think it depends how close a person lets you get, you know, it's like for example if you had a patient who is very upset or he doesn't want to talk to anyone you can't treat him with compassion because he won't let you talk to him, he won't let you help him. You can't show any compassion to somebody when they feel and act like that. You will probably go and ask him how he is but that's pretty much about it, they don't want strangers coming in, we are strangers to them. I think that maybe they want just the family close to them not nurses, maybe they just want nurses to give them the treatments so it depends on the person, their personality. If they want to be treated you can treat them or you can treat them with compassion, really show them that you care for them. I think as a nurse you use your abilities and your skills to try and talk to every patient to try and show compassion no matter what.

Kat is indicating that she believes that as a nurse there is a need for a patient's consensual cooperation if she is to be able to be firstly empathetic and then compassionate towards a person. Howe (2013) and Kohut (1977) have indicated empathy is an essential preceding component to compassion. They further suggest that if empathy is to be used constructively to its full benefit, it is important to know more about the person than is overtly obvious or through information provided by a third party. To obtain this knowledge there needs to be personal two-way communication between the nurse and the patient, which enables the nurse to explore the psyche of the person and get to know them. Rogers (1957) acknowledges that information gathered through personal dialogue is important to establish how the person views the world.

Kat is indicating that sometimes she is prevented from doing this if the person cannot or does not want to communicate, saying that demonstrating compassion becomes difficult when the patient “is very upset” or “he doesn't want to talk to anyone”. The decision that the person takes not to interact hinders her in demonstrating empathy and compassion (“you can't treat him

with compassion because he won't let you talk to him, he won't let you help him".) By saying this, Kat could in the first instance be described as uncompassionate; she is dismissive, feeling that she cannot be compassionate because the person does not want it.

She does not appear to understand attachment styles, which can explain why a person is unwilling or unable to accept help from others (Siegel, 2007a). Sheehan *et al.* (2013) support the idea that Kat is unknowingly continuing to be compassionate, as compassion needs to be uniquely fashioned to meet the requirements of the individual. Kat is supposing that you have to “*treat*” or give something to someone to be compassionate, but it could be that in some cases compassion is about doing nothing if that is the person’s choice. She is implying that there needs to be contact for compassion to occur, in this instance referring to contact through speech.

Yes, individualised fashioning does requires communication to occur. Communication, however, can take varying forms: for instance verbal, non-verbal, and through facial expression and body language (Riley, 2012). When Kat says “*You can't show any compassion to somebody when they feel and act like that*”, she indicates she is not being allowed to be compassionate in the way she would like. By subtly indicating that compassionate acts are negotiated between herself and the patient (Stebnicki, 2007), Kat appears to be indicating that compassion is something to be bargained for, the bargaining occurring between the patient and the nurse.

Egan (2007) suggests that the final say and the responsibility for whether compassionate care is accepted appear to lie with the patient, as empathy also encompasses understanding personal reasoning. As Kat says, “*You will probably go and ask him how he is but that's pretty much about it*”. By acting in this way Kat is demonstrating the capacity to understand that the patient’s wishes outweigh her emotional need to demonstrate compassion. It appears to be absolute, in that she can only ask and if refused then she feels she can do no more; but she is “demonstrating unconditional positive regard” (Stebnicki, 2007, p.322). Kat is signifying that to provide care she has to gain a patient’s approval and cooperation. Constructive or silent dialogue between Kat and the patient is important: it is not only to be viewed as conducive to

compassionate care, but also compassionate in its own right (Somogyi *et al.*, 2013).

Although Kat acknowledges that it is the patient who decides whether to accept compassion, she tries to “*show compassion no matter what*” (DH, 2012a). This appears to contest the idea about unconditional positive regard, as there cannot always be an ‘exchange’ between the nurse and patient. When a patient decides not to be part of this interaction of compassionate exchanges, it can result in either negative or positive outcomes for both parties (Sprecher & Fehr, 2006). Hatfield *et al.* (1994), and Keltner and Kring (1998), also allude to the fact that reciprocal emotional interactions are of mutual benefit within relationships. These benefits include cooperation, shared harmonised thoughts, closeness and understanding. If the patient refuses to have a relationship, this can be viewed negatively as it more than likely hinders the nurse’s ability to demonstrate compassion towards them.

5.4 Emerging close relationships

Kat refers to a feeling of closeness between her and the patient that enables compassion to be part of the process of being able to help them. She indicates that there are different levels of closeness as she says that the person may want, “*just the family close*”. It is the interaction between her and her patient that in her view is indicative of the compassionate practice she is able to demonstrate towards them (Sprecher & Fehr, 2006). This suggests what Keltner and Kring (1998) refer to as an intimate level of closeness that is established between nurses and patients in their care, which impacts on the amount of compassion that Kat is able to show and the patient is willing to accept.

Kat highlights a lack of a therapeutic relationship between a patient and a nurse that may be caused by a lack of attachment between the two.

Attachment theory is a psychological model that, according to Ainsworth and Bowlby (1991) and Bowlby (1969/1982), influences the dynamics within relationships that occur under specific circumstances. The dynamics and circumstances involve those relationships that can be directly related to patients when they are removed from their normal environment. People when they become patients can suffer the adverse effects of experiences of

loss, separation and rejection. These experiences of emotional upsets, hurts and sickness, love and acceptance, differ with and towards each caregiver (Howe *et al.*, 1999, p.37). Kat refers to the patient and patient choices being influenced by their lack of attachment to the nurse (*“they don’t want strangers coming in”*), and acknowledges that some patients view nurses as strangers (*“we are strangers to them”*).

Kat continues with the importance of family relationships and attachment within a hospital setting. By saying *“they want just the family close to them”*, Kat is suggesting that at times she thinks that patients feel that it is their families that are the appropriate people to offer the emotional and practical support they need. There is one exception, however: in adding, *“maybe they just want nurses to give them the treatments”*, Kat is suggesting that some patients themselves think that they do not need to have a caring or compassionate relationship with a nurse to receive therapy. Smajdor (2013) has also made this point in her work: treatments do not need to be delivered compassionately, but they do need to be delivered effectively. She differentiates at this point between compassion and treatments, and explores the idea by suggesting that treatments can be given without establishing a relationship which extends beyond the therapeutic. The indication is that some patients are more comfortable with this arrangement, allowing the family to be the main provider of compassion. This changes the power basis, from assuming that compassionate care within a hospital environment is almost the total responsibility of the nurse to allocating it to the relatives.

5.5 Forging emotional attachment in practice

Kat went on to share her experiences demonstrating that sometimes she and a patient develop a relationship that transcends caring for a person, and becomes an emotional one, a relationship in which the patient and Kat get to know each other differently. She recalls the times she became emotionally attached to patients:

I have cared for all of my patients but there are times when I feel different, nobody else would know that I feel different as I treat all the people the same, I just know that some people feel differently about me and I feel differently about them. Before I started nursing I was not that compassionate towards people

and I was probably just emotional with my family, I mean I didn't used to work in this field so it was new to me to show compassion to everyone. I don't think I used compassion a lot before.

She begins by acknowledging that she has “*cared for all*” of her patients, yet “*there are times when I feel different*”. These feelings appear to transcend what Kat believes to be the standard caring relationship, and are not present with every patient. Sometimes she becomes differently attached to a person and the emotions she experiences surpass those experienced when giving normal care.

Field (1996) specifically relates these feelings or emotions to those of compassionate love. Sprecher and Fehr (2006) acknowledge that the compassionate love to which Field (1996) refers is different from romantic love, and it is this type of love that Kat feels for some of her patients. Kat also states that compassionate love does not lead her to differentiate between her treatment of patients (“*I treat all the people the same*”). This is in contrast to Sprecher and Fehr (2006) who suggest that compassionate love leads to increased reciprocal benefits (p.233).

If Sprecher and Fehr are correct, this suggests that Kat is more likely to treat differently patients that she feels compassionate love towards. What she says next is very important, and both confirms the thoughts of Sprecher and Fehr (2006), Hatfield *et al.* (1994), and Keltner and Kring (1998), yet proves contradictory in that she suggests that there is a reciprocal and interactional relationship based on compassionate love. She goes on to state that she just knows that “*some people feel differently about me*” and “*I feel differently about them*”. This confirms that on some occasions Kat and the patients in her care form a reciprocal professional relationship that, she expresses, transcends that which is usual within a therapeutic relationship (NMC, 2013b). The feelings that she talks about are different from those she normally feels towards a patient, and could result from a deeper emotional and perhaps more meaningful attachment. This deeper attachment occurs often for reasons that are unspoken and often does not relate to conscious thought.

Kat continues to associate the compassionate and emotional feelings that she has with those that she feels for her family. This portrays the messiness of compassion, emotions and attachment as they become intertwined both in the practice and the family arenas. This entanglement occurs not only within Kat's practice, but is also related to the emotional attachment and compassion she feels towards her family members. She relates to her emotional and compassionate experiences prior to entering nursing as she recalls, *"Before I started nursing I was not that compassionate towards people and I was probably just emotional with my family"*. Kat is making two points here: the first point supports what Kerr (2000) says of Bowen's (1978) family systems theory and the impact that it has on a person's ability to be emotional and show emotions to others outside the family unit. The theory suggests that a person who grows up in a family whose members are emotional with each other is more able to be emotional with strangers. Kat is saying that she has been given the opportunity in her role as a student nurse to be compassionate to strangers, an opportunity that is new to her. Secondly, she is supporting the thoughts of Schantz (2007), von Dietze and Orb (2000), Gross and Thompson (2007), and Lazarus and Folkman (1984), who believe that student nurses use emotions, feelings and compassion interchangeably to describe similar experiences. This is what Kat does, as she mixes up the terms of compassion and emotions while using them in the same vein.

Since commencing the nursing course her ideas around who she is allowed to demonstrate her emotions and compassion to have extended from her immediate family to being able to *"show compassion to everyone"*. Her personal ideas and knowledge of what is demonstrably appropriate compassionate and emotional care towards strangers have changed. She indicates that it is appropriate to use compassion in *"this field"*. Benner (1982) and Hayward and Tuckey (2011) have provided reasoned arguments for student nurses learning about and experiencing emotions and compassion before applying them within the nursing context. Both have indicated that the application of compassion and the unravelling of emotions is a learning process that occurs through experiences. As learning takes place, nurses become more proficient and confident in their demonstration of

compassion towards strangers. Kat upholds these thoughts: she herself says, “*it was new to me to show compassion to everyone*”, but she extends the feelings she had experience of with her family members to all in her care:

My compassion has come out in my training because I have seen so many people suffering, it was the feeling that came, feeling that came without me trying really hard.

Those feelings of compassion have been awakened by being given permission, through her nursing role, to extend her compassion to strangers. As Ainsworth and Bowlby (1991), Bowlby (1969/1982), Cassidy and Shaver (1999), and Nelis, Clare and Whitaker (2014) have indicated in reference to adult attachment theory, the ability to demonstrate compassion in adulthood relates to experiences of attachment as a child. It appears that the compassionate traits that Kat demonstrates have been triggered, awakened, through her encounters with and perceptions of suffering: indeed, Kat indicates that it is through her experience of encountering the suffering of others within clinical practice that, in her words, “*it came out*”. This emergence of compassion is substantiated in the works of Reich (1989), von Dietze and Orb (2000), and Nussbaum (2001), who suggest that compassion is cognitively activated.

5.6 Compassion is multifaceted

Making tangible her thoughts and opinions on her experiencing and using compassion, the next part of Kat’s narrative contained a mixture of all the themes, emotions, empathy, attachment to patients and learning through communities of practice. She begins:

There was a lady who had a rare form of cancer of her heart, she was due to have surgery and was moving to another hospital. I would talk to her whenever I could, it was easier for me to go and have a chat and whenever I did I knew she was really really worried, I could speak to her and she could speak to me. I learnt something when I was talking to her and asked her if I could tell the doctor, she did not realise the significance of what she told me and I thought, I knew that it would make a difference in her treatment. I just wish I could do something to alleviate her suffering, to tell her something which could make her feel better but unfortunately there was not a lot I could do. I just sat with her and tried to encourage her she was really really worried and the only thing I said to her that was I am sure I'm going to see you again, I did think that I was going to see

her again, I really did, I wouldn't have said that if I didn't think that I would.

Here, Kat senses that this person needs her support, perhaps more than the other patients did at this time; she prioritises her time and believes that by talking to the patient it would help allay her fears. This may be an example of reciprocal and compassionate love being applied. She demonstrates empathy and compassion in that she realises that the person is experiencing distress and tries to alleviate it by talking with her, Kat reassuring and the patient being reassured as much as possible with regard to her condition and prognosis. Kat demonstrates an empathetic style of communication that depicts sincerity, along with truthfulness and optimism (Parker *et al.*, 2007).

During the conversation Kat appears to have been offered information that she thought was crucial to report, as she asks permission to do so (*"if I could tell the doctor, she didn't realise the significance of what she told me.... I knew that it would make a difference in her treatment."*) Kat does not realise or value the importance and benefit of her communication within compassionate practice (*"there was not a lot I could do"*). Kat seems to relate 'doing something' to dispensing treatments or carrying out care that involves physical interaction, or feels that 'doing something' was itself absolute in ridding the person of their disease. Although acknowledging the importance of communication, Kat does not appear to appreciate its full value: there is an undertone of helplessness on Kat's part, as she appears to underestimate the value of therapeutic communication and its place within holistic care. The benefits of therapeutic communication are well established within nursing, and it is known to positively influence patient care and patient outcomes (Tobin & Begley, 2008). McCabe and Timmins (2006) explain that understanding of patients' individual needs is necessary to provide best practice and compassionate holistic care. To understand those needs requires effective communication between the nurse and the patient. There is a definite and vast benefit in communicating with patients, as it is through communication that an understanding of the person's deepest suffering is established (Kohut, 1977; Howe, 2013). These informative details can be pertinent to the person's physiological, psychological and sociological wellbeing if used in attuning individual plans of care.

There is also evidence of attachment developing, as she says that it was a two-way conversation, and of an underlying sense of trust and confidence developing between the two. From Kat's perspective, the trust emerging between her and the patient is also extended to the doctor who is caring for the patient, when the patient imparts information that Kat sees as significant in planning her care. However, Kat feels that she needed the person's consent and asked *"if I could tell the doctor"*. This points to Kat thinking that the conversation was confidential and the patient was trusting her. The confidences and trust extended to Kat were important enough for her to cherish, and Kat sought the patient's permission to impart information so as not to break the intimate relationship that had developed between them. Trust between individuals is often fragile and not easily repaired if broken (Sellman, 2006; NMC, 2013b). This relationship was probably established over time as the number of encounters between them grew, Kat speaking to her *"whenever I could"*.

Kat also appears confident that she can approach the doctor with information that she thinks is crucial to her patient's care, as she *"knew that it would make a difference in her treatment"*. Kat perceives that she has a professional and trusting relationship with the doctors, and she feels comfortable sharing significant information with one of them; there is an underlying trust between Kat and the doctor, an assumption that she will be listened to. Kat deduces that medical rather than nursing interventions are required, as she herself could instigate changes to her patient's nursing care (NMC, 2010). Similar issues of trust that occurred between Kat and her patient are now transpiring between Kat and the doctor: Kat has to call upon the trusting relationship that Peter and Morgan (2006) refer to as worthwhile, as Kat becomes vulnerable to the response of the doctor that she approaches. She has to be confident that she will be listened to, otherwise the trusting relationship that she perceives exists between the two professionals is at risk. Kat exposes her vulnerabilities, as she has to rely on the doctor's response to the information she gives expediting changes to her patient's care that Kat believes will be beneficial (Sellman, 2006). An interesting reversal of need is emerging, one that was first evident between Kat and the patient, and then between Kat and the doctor.

5.7 The importance of inter-professional relationships

In the next part of her story Kat gives further examples of how she developed inter-professional relationships while working on a particular ward. The dynamics of the ward appeared to be different from other wards where Kat had worked. The difference had positively influenced her learning in practice:

I was part of the team on that ward, I could go to the doctor with information, I could go to anyone, and well it was more than a team, everyone worked together. When I think of a team I think of us as nurses, the doctors, the physios [physiotherapists], all doing their own jobs, they have their tasks and we have ours. I've worked on wards like that. This was more, I learnt more, it didn't matter what you were, your opinion counted and mine counted. When I told the doctor what I found out, even though I knew it was important, she explained to me, she was great, she drew pictures of the heart and she explained to me why it was important that she knew what I told her. We had meetings where we discussed plans of treatments, the patients also got involved, that was good, they had a say in what was going to happen, they had more than a say, they were like part of the meeting. We learnt from each other, we learnt from our patients. This ward was different, I wish all the wards were like this.

Kat begins with her recollection of how she was integrated into working within a team (*"I was part of the team on that ward"*). According to the RCN (2014) and Salas *et al.* (1992), a team is two or more people working together towards a common goal, each having a particular job to complete. Kat reflects the thoughts of Wenger and Traynor (2011) that teams are held together by the tasks that they are involved in at any one time. When referring to teams she indicates that she believes different professions work in silos, as they are *"all doing their own jobs, they have their tasks and we have ours"*. Within her description, she expands on her thoughts that she was actively situated in an environment that was operating differently (*"it was more than a team, everyone worked together"*). Everyone working together, across perceived or real boundaries, relates to the philosophy and dynamics that characterise communities of practice [CoP] (Wenger, 1998; Lave and Wenger, 1991). Kat indicates that she had *"learnt more"* in this environment and that there was mutual trust, respect and learning between different professionals – a professional community. Macmurray (1961) speaks of these qualities within communities where people can be themselves and

exchange information to the benefit of all. Kat at this time was situated within a placement where there was multidisciplinary respect, and where all views mattered (*"your opinion counted and mine counted"*).

Professional communities as first described by Goode (1957), then expanded upon by Lave and Wenger (1991), Brown and Duguid (1991), Wenger (1998), and Lesser and Storck (2001), are bound together by commonalities, one of which may be compassion, and by their common sense of identity and their sharing of knowledge. This sharing of knowledge is evident when Kat says, *"she [the doctor] explained to me, she was great, she drew pictures of the heart and she explained to me why it was important that she knew what I told her."* This example indicates not only the learning and teaching that occurs between professionals, but that there is mutual respect (NMC, 2010; Benner *et al.*, 2009). Respect and situated learning are manifested as the doctor went on to confirm and explain in detail to Kat the importance of the information she gave her.

Gobbi (2009) alludes to features that need to be present for situated learning to occur within communities of practice. Some of those features are present within Kat's narrative, including that choices have to be made. There are a number of decisions made by all parties, including the patient, during planned meetings where *"we discussed plans of treatments, the patients also got involved"*. According to Gobbi (2009, p.68), decisions, consultations, shared practice and the involvement of the patient all influence positive aspects of situated learning in practice. It was through patient consultations that the members of the CoP learned and could adjust their practice to benefit the patient; this made care individualistic and tailored to meet the patient's needs.

5.8 Learning and teaching in the university

Kat continued to relate to experiencing compassion within the context of teaching and learning in the practice environment, by comparing it to her experiences within the university arena:

I don't think it is something you can teach because I think it's a feeling, it's the way you are. I think it has to be in you, I don't think you can teach somebody to do compassion. I think you can see it in nurses, all your mentors, you see the way that

they treat patients and see the way they talk to them and the way they behave, and you pick up on those things. It's not that you're learning compassion, it's that you are using what's already there in you.

Kat does not think that you can teach compassion, believing that it is an inherent trait and part of who you are. Like Gross and Thompson (2007), Lazarus and Folkman (1984), and Oschner and Gross (2007), Kat associates compassion with feelings: as Kat herself says, “*I think it's a feeling.*” These authors suggest that sometimes the word ‘feelings’ is substituted for the word ‘emotion’. Kat claims that feelings [compassion] are inherent, part of who you are. She feels strongly about compassion being an inherent quality which cannot be learned, as she says this twice in this short excerpt. This aligns with Tangney and Fischer’s (1995) theory that emotions are both evolved and inherent. She says that she looks to others, namely her peers within practice, to see how they interact with and treat patients, and then adapts her compassionate behaviour in accordance with what she learns. Kat thinks she is working in a community where compassionate practice is the norm, and looks towards her colleagues to “*see the way that they treat patients and see the way they talk to them and the way they behave, and you pick up on those things*”. It is not unusual for student nurses to observe practice and adapt it to enhance their own practice and skills (Dreyfus, 1981; Benner, 1982). It is through situated learning and experiential learning in practice that student nurses learn to synthesise their emotions, and integrate them into compassionate practice (Dreyfus, 1981; Benner, 1982; Hayward and Tuckey, 2011; Theodosius, 2006).

Kat ultimately turns her attention to how compassion is taught in the university arena:

I think I said that nobody can teach you compassion, but I think that at the university they do try to teach you everything you need to do in practice so you know a tutor says ‘you should be kind to everybody, you should not be doing that, you should try and treat them kindly’, I think this is related to compassion, but it's not learning compassion. You can't go on the wards and treat somebody in a nasty way because we know that you need to show compassion, compassion needs to be experienced, it happens when you see people suffering or that need your help, then you learn what compassion is, you feel and use empathy, but real compassion is there, it's waiting to be used. I think that

through ethics and skills, role-play we learn things that affect care, but we do not learn compassion in university. How can you? You have to experience suffering.

In this part of her narrative Kat remains adamant that it is impossible to teach compassion in a university setting. However, she does think that there are underpinning principles that help uphold compassion within practice that can be and are taught within the classroom (*“at the university they do try to teach you everything you need to do in practice”*). This relates to the thoughts of Pence (1983), Kellehear (2014), and McEwen and Wills (2014), who have suggested that causal values can be taught as theory but do not necessarily have an impact or reflect the values of the students and their practice. The theories to which Kat refers are taught in a variety of ways, but these are not (according to Kat) effective in initiating true compassionate feelings. According to Kat, you have to experience the precursor to those feelings and the emotion that empathy initiates: *“compassion needs to be experienced, it happens when you see people suffering or that need your help, then you learn what compassion is, you feel and use empathy”*

Kat compounds her thoughts and agrees with Hayward (2010) who suggests that skills acquisition through role-play has a place in student learning, to help underpin principles related to compassionate practice. Kat’s view is *“I think that through ethics and skills, role-play we learn things that affect care, but we do not learn compassion in university. How can you?”* Kat finishes the interview in the same vein as she commenced, saying *“You have to experience suffering.”* It seems that this release of compassion is only achieved within the authentic habitus in which it occurs and when genuine patients are involved. Hooks (2010) and Cope *et al.* (1999) would agree with Kat as they articulate that knowledge of theory is different from knowing in practice.

5.9 Summary of Kat’s story

Kat gave her own personal and moving account of her significant perceptions of compassion. She thought that compassion was an inherent trait that was particularly activated by seeing and experiencing the suffering of others in distressing situations. She believed that the suffering she witnessed

activated feelings, leading to emotions that were so powerful that she felt compelled to alleviate the distress she was seeing as quickly as she could. The feelings and emotions that she experienced were overwhelming, which she describes as a physical pain; she became immersed within the patients' distress. These experiences resonated with emotional labour that at times, as she recalled her experiences, became so painful that she metaphorically removed herself and used the second person pronoun. This helped her to put some distance between now and the painful memories and so helped suppress the distressing reaction to the suffering she has previously experienced.

Kat thought that patients had to agree for her to help them in a manner she thought was compassionate. This agreement between them then led to a better relationship that could lead to attunement. She was quick to point out that where this did not occur then care could still be given, and she distinguished between care given compassionately and care given efficiently. She understood that the patient's wishes on how they wanted to be treated took precedence over her wishes. Reciprocity also contributed, in that it allowed Kat to get to know and become attuned to her patients. She said that attunement supported a nurse in their efforts to be compassionate.

When talking about the importance of forging relationships between herself and patients, Kat thought a person's attachment trait influenced their ability to accept and demonstrate compassion. Before she became a student nurse she only demonstrated compassion within her family, but has changed her attachment style following experiences within the programme. Kat also referred to patients and the impact of their personal attachment style affecting their ability to accept compassionate exchanges from nurses.

When Kat turned her story to learning and teaching, she thought that compassion could not be learned or taught within the university setting. She suggested that she can learn theories and skills through role-play and this does help her clinical practice. Although she acknowledges that theoretical and experiential learning is of benefit, she values learning in practice more. She differentiates and separates her learning in the university setting from the emotions that she learns from looking after patients. She was very sure of that and said that it was only the experience of suffering in an authentic

setting that added to her knowledge of compassion. It was experiencing the suffering of her patients that really taught her about compassion.

Kat said that it helped her learn about compassion and being compassionate in practice when the ward has a CoP philosophy. This philosophy appears to break down barriers, real or perceived, between different professions and facilitates a community of compassionate practice. Kat found it beneficial to be part of a community where she learned from other professionals; but what was important to her was that they also learned from her. They respected her as a professional in training. Kat finished her account on an important point: that patients were similarly listened to. This affected the way that professionals within the CoP fashioned the treatment to meet each patient's individual needs.

Chapter 6: Elizabeth's Story

6.1 Personal Introduction to Elizabeth

I have come to know Elizabeth very well over the three years that she has been on the programme, and during these years I have been able to support her as she has developed her clinical and academic prowess.

Elizabeth is a mature student, married with three children under the age of twelve. Before entering the nursing programme Elizabeth had been a healthcare assistant for many years. Elizabeth provides a unique insight into how she views compassion as a student nurse, having previously had vast experience of healthcare work. Her decision to become a nurse had not been easy from a financial and educational perspective, as she had to go back into further education to gain the qualifications she needed to be considered for the course. After gaining the correct qualifications by distance learning, she and her family had to consider the financial implications of giving up her employment to join the programme.

6.2 Elizabeth's definition of compassion

Elizabeth commenced her narrative by describing what compassion looked like to her:

Me personally it's just, I was thinking about it on the way here, it's just empathy towards another human being, a person, seeing their distress and having a feeling for them. Not knowing exactly what they are going through, but trying my best to find out and understand them, feel what they feel. It's like having a family member in the bed, it's like a human interaction. They need to want it though. I think everybody's got it, but shows it differently.

Elizabeth begins by using the words “*me personally*”, hinting that in her opinion compassion has a different meaning to different individuals (Hayward and Tuckey, 2011). Elizabeth uses the words “*empathy*” in conjunction with “*feeling*” which is provoked by “*seeing*” distress. Witnessing distress is known to not only initiate feelings and physical reactions that result in emotional experiences, but is also a principal factor in cognitive empathy (Tortora & Derrickson, 2009; Plutchik, 2002; Howe, 2013; Hojat, 2009).

Howe (2013) and Hojat (2009) when they refer to cognitive empathy base their ideas upon contributory factors that are crucial if cognitive empathy is to

be experienced. One factor to which they refer is what Elizabeth herself states influences her to have a feeling towards another person: through her sense of sight, she perceives, processes and recognises events as distressing. The principle of contributory factors is based on witnessing the distress of another, then using cognitive appreciation to place oneself as nearly as possible in a position to imagine and understand what the other person's psychological experience is from their perspective (Howe, 2013, p.14). When cognitive empathy is at its most effective, Elizabeth is not only able to comprehend and sense the patient's experience, but mutually parallel her experience of the situation at the same time. This lets her demonstrate empathy and act in a manner that she thinks is appropriate (Myers, 2004; Hayward & Tuckey, 2011).

6.3 The multifactor nature of compassion

Elizabeth then indicates that compassion to her is multifaceted as she uses the words "*empathy*" and "*having a feeling*" in conjunction with each other. Elizabeth is not alone when believing compassion to be multifaceted as it is common to mix and overlap the meanings of empathy, emotions and feelings to consolidate the description of compassion (Purdie *et al.*, 2008; Stebnicki, 2007). Elizabeth also appears to be entwining the facets of feelings and emotions and using them in the same vein. This is common as feelings and emotions are closely related, but it is "popular to insist that emotions are not feelings" (Prinz, 2005, p.9). It is widely thought that a person must experience feelings triggered through the senses if they are to experience an emotional reaction (Gross & Thompson, 2007; Lazarus & Folkman, 1984; Oschner & Gross, 2007; Purdie *et al.*, 2008).

When Elizabeth says "*It's like a human interaction*", she is indicating that compassion is a two-way process between herself and the patient, each taking a role so compassion can be used in the caring process. The interaction or two-way process to which Elizabeth refers may be reciprocal, benefitting both parties. The interactions or encounters between a nurse and a patient can be different in terms of reciprocity, as when a nurse offers benefits – for example, in the form of care or treatment – then often the nurse does not know if it is to be of personal benefit to them: they cannot be sure if

the response they get from the patient will involve reciprocity (Molm, 2010). Because Elizabeth cannot be sure of the reaction of any of the patients in her care, it could be that the act of compassion is of unequal reciprocal personal benefit to her. It may be that it is enough that Elizabeth intrinsically appreciates the efforts that she makes in an altruistic vein. She values her efforts, and views the sharing of her compassionate love as recompense and of value to herself (Underwood, 2008).

As she has already indicated, she believes that both parties have to be consensual for a closeness or adult attachment to develop through interaction (*"They need to want it though"*). It could be that Elizabeth is aware that both her and her patients' attachment styles affect their interaction. Elizabeth thinks that the patient needs to want to cooperate with the nurse for interaction to occur. What Elizabeth may be unaware of is that the patient may have an attachment style that makes interaction difficult. To expand, it is thought that there are four types of adult attachment styles, each affecting the ability of an adult to interact and have relationships with other people. A secure attachment style corresponds to the traits that Elizabeth is displaying. This attachment style is associated with that of compassionate love; the type of love that surpasses that of romantic love (Sprecher & Fehr, 2006). A person with a secure attachment style or personality is thought to have a strong sense of self; they want and have the ability to form emotionally close associations with others. Elizabeth will find it easier to interact with patients who also have and display this attachment style. This is because the traits associated with the other three attachment styles are not conducive to interactional relationships (Bifulco & Thomas, 2013).

Closely associated with reciprocity is the evidence that as well as an interaction, there is also a relationship occurring. The relationships to which Elizabeth refers involve trust and intense and acute attunement to another person, as she endeavours to *"understand them, feel what they feel"*. Elizabeth's attunement to another is also about the reciprocity that occurs between herself and the patient (Field, 1996). Attunement according to Siegel (2007a, 2010) is more than just identifying another has needs and wants, it is about uncovering and accepting a person's essence and accepting the reaction(s) that occur within oneself. Applied to nursing, it is

about reaching out to another and connecting, accepting and understanding the needs of others in an effort to alleviate or mitigate their distress through acts of compassionate caring. Attuned relationships within compassionate caring can lead to benefits for both the caring and the cared for; as Epstein and Street (2011, p.457) say, “attunement implies that the patient and family can be the focus of care as well as de facto members of the health care team”.

As Elizabeth continued, very early in her narrative she compared the feelings that she experienced when demonstrating compassion to those that she has towards her family: *“It’s like having a family member in the bed”*. Elizabeth does not label the person as a patient as she describes them in relation to how she sees and values her family members; this is itself an intimate comparison. She is looking on the person in her care as a member of her family, which has implications for both her acquired attachment and her family caregiving systems. The implication primarily for Elizabeth and her patients is her resilience in the way she deals with and demonstrates compassionate care. This is because there are similarities between attachment theory and family caregiving systems: at a conceptual level they are “what draws people together, what drives them apart, how they deal with conflicts and intergenerational transmission” (Rothbaum *et al.*, 2002, p.229).

The theme of attachment, attachment theory and compassionate love in adult life was evident throughout her interview and proved to be nonlinear within her narrative. She often referred to and made numerous links between the compassion that she experienced when looking after a patient and that of looking after her family. She continued:

It's about just being able to show empathy, and to show caring for somebody, it's like soothing a child, soothing the patient who is in pain, who's suffering and upset. It's like being able to show that understanding and empathy and to be able to calm them down, soothe them and show them a bit of love I suppose. It makes them and me feel better. You know, not love love, not love like you show your partner or your children, but show them that you care, you know what I mean, like the whole thing. I don't know how to explain it really.

Elizabeth associates the feelings that she has for a patient with those she would show towards a child in distress. Elizabeth recognises a cue that the

person needs calming, and then relates demonstrating empathetic and caring feelings that she has towards a patient to the actions of “*soothing a child*” (Siviter, 2012; Howe 2013). She views patients in distress as being vulnerable and childlike, requiring substitute parental reassurance that the distress will pass and the problem will be resolved. In her actions to soothe the distress, she takes a parental and pacifying role; by taking a controlling role, she is not only able to demonstrate compassion but also alleviate distress (Gilbert, 2010; Cole-King & Gilbert, 2011; Siviter, 2012).

Elizabeth goes on to differentiate between romantic love and compassionate love, directly reflecting the thoughts of the NMC (2013) and Sprecher and Fehr (2006). She analyses the two types of love that she has for her family and her patients by saying “*not love like you would show your partner or your children*”. Although making a distinction between the feelings she has for the patients in her care and her immediate family members, it is a very intimate and profound statement that she makes in comparing and contrasting her feelings that leads to reciprocal benefits. Elizabeth also introduces the idea through her supposition that she positively influences how she and her patients feel (“*It makes them and me feel better*”). To associate feelings that pertain to a form of love indicates the forming of a bond, a relationship and, in the case of patients, feelings of compassionate love for a stranger.

6.4 Experience as a patient and the importance of family

The sense of vulnerability that Elizabeth relates to is closely connected to the values and beliefs that she associates with her family attachment traits. In the following part of the narrative, she discusses the care that she received while in hospital having her children. Her personal account demonstrates how she was soothed when she was a patient, and her experience led to a deeper understanding of compassion and the ability to demonstrate compassionate love towards her patients. It altered her positive affective and cognitive state: as Cole-King and Gilbert (2011, p.32) suggest when relating to personal experiences, “the evolution of attachment and affiliative behaviour helps explain how it is possible to be emotionally invested in others”.

I've come from a loving family and I like to pass on some of that love to other people. I know that I needed help when I was having my children and I received compassionate care. It helped me to experience compassion from the other side, the nurse who looked after me stroked my hand and soothed me and it helped. I couldn't help myself, I was distressed and the nurse told me it would be OK, she took control. I know what it's like to need compassion and to receive it. I just like to think that those experiences have helped me with my compassion, of when to use it and how to use it with different patients.

In relating to her past encounters, Elizabeth is indicating that her views of compassion have been influenced by personal experiences that began in childhood and have continued into adulthood. She indicates that her upbringing was loving (*"I've come from a loving family"*) and believes that she understands love as a positive attribute which she is willing and able to share with patients. In demonstrating how her family influenced her attachment trait, which falls into the secure category, Elizabeth reflects the thoughts of Howe *et al.* (1999, p.57) discussing the associated behaviours: "Secure... adults acknowledge the value and impact of attachment relationships." A person who has developed these traits is able to offer a high degree of understanding and reassurance to those who are distressed. Siviter (2012, p.24) says developing secure attachment traits contributes to the ability of a person to demonstrate compassionate love, empathy and care to others.

Elizabeth is aware that she has the ability to show compassionate love to others outside her family circle as she says, *"I like to pass on some of that love to other people"*. She is comfortable showing what she describes as the deep and personal emotion of love, extending it into an intimate relationship to strangers. As well as being related to her attachment style, this also shows the influence that family system theory has upon her: the similarities of attachment and the personal development of family systems experienced as a child have far-reaching effects into adulthood. Although there are subtle differences between the two, "theorists in both camps emphasize the ways in which these differences in orientation complement one another" (Rothbaum *et al.*, 2002, p.329). The impact of attachment experiences is focused upon the individual when a child, while the impact of family systems is focused on the dynamic working of groups as an adult (Bowen, 1978).

The positive attachment traits and strong familial beliefs that Elizabeth holds have developed from the love she experienced within her family from childhood, and continue to the present day. Elizabeth is demonstrating attachment traits associated with the secure attachment style (Bifulco & Thomas, 2013), and is comfortable with demonstrating interest and affection while being able to trust people (Bartholomew *et al.*, 2001). A characteristic of secure attachment style is the ability to share the positivity with others. Elizabeth demonstrates this ability with others that she now encounters in a nursing situation. She feels at ease to share with people who in her view would benefit from a compassionate or a 'loving' encounter (Mickelson *et al.*, 1997). Elizabeth is indicating that love helps the person who needs aid in supporting compassionate actions, but is also a positive reciprocal emotion (Sprecher and Fehr, 2006). This is not to say that if you have not experienced a loving family upbringing then you are unable to show or experience compassion and love, as the ability to change one's philosophy, behaviours and beliefs lasts throughout life. Changing one's attachment traits was explored by Ainsworth (1989) who suggested that sharing experiences with others through life leads to "affectional bonds" (p.715). It is this bonding or the developing of relationships that Elizabeth appears to have, and which others have the potential to develop.

Having experienced compassion from "*the other side*", Elizabeth is using what might have turned out to be a negative experience ("*I know that I needed help when I was having my children*") into one that is positive (Hatfield *et al.*, 1994). She indicates that in her time of need a nurse cared for her compassionately ("*I received compassionate care*"). Part of what Elizabeth viewed as compassionate was when the nurse "*took control*" as Elizabeth was so distressed that she "*couldn't help*" herself, and she learned from this. Elizabeth was central to the scenario that she describes: she herself was experiencing a personal distressing event. Although unable to help herself, she was the focus of events and witnessed and experienced another nurse's compassionate response, their judgements of her plight. These are the judgements that Plutchik (2001) says occur as a result of witnessing distressing events, and that as well as triggering emotions, lead to actions that relieve the suffering. The witnessing of distress helped the nurse

rationalise events leading to emotional responses. The witnessing and the response appear symbiotic, reinforcing each other in the “knowledge-generating process, expressed, for example, as emotional acuity and thought sensitivity” (James *et al.*, 2010, p.2),

Elizabeth learned from what could have been a negative personal situation of needing compassion in difficult circumstances, and incorporated her experience into her emotional knowing (Hayward & Tuckey, 2011; James *et al.*, 2010). She now believes she is aware of what compassion entails from a patient’s perspective as well as from her role as a nurse. Elizabeth is able to incorporate her experiences into her clinical practice positively, to enhance her compassionate persona and compassionate practice. The experience and the effect it had upon Elizabeth also supports the thoughts of Clarke and Clarke (1998, p.435) that attachment styles and the influence of family systems in early childhood can change and develop throughout life. Expanding upon this, it is also suggestive that attachment styles can be reinforced through personal learning experiences as Clarke and Clarke (1998) say “early social experience by itself does not predestine the future” (p.436). This can occur even when a person’s childhood (like Elizabeth’s) has been one that results in a secure attachment and familial systems: as Elizabeth says, *“I just like to think that those experiences have helped me with my compassion, of when to use it and how to use it with different patients.”* Experiencing compassion from a different perspective – of someone requiring care rather than caregiver – expanded her knowledge, which she was able to reflect upon and positively incorporate into her practice (Schön, 1983, 1987).

6.5 Experience as a foundation to support practice

Continuing with adult attachment as a sub-theme, Elizabeth recounted the still raw and emotional experience of looking after a young man who had tried to commit suicide. This episode in her nursing career was particularly emotionally challenging to Elizabeth:

I have been nursing for quite a few years now. I have dealt with a lot of things but recently I dealt with something that completely knocked me. I mean, it really knocked me. There was a young man who tried to commit suicide, his family were

completely unaware of his and their situation and they came to A&E [Accident and Emergency department] after a phone call from us. When they arrived they couldn't see him at first as we [the staff] worked on him in resus [the resuscitation department]. I could see their distress, I felt distressed. At every opportunity, when we had their son settled, we would bring them through to discuss what was happening ensuring that they knew, it was so important that they knew and we got information as well. All we got off the family was, you know, 'thank you' they kept saying 'thank you' 'thank you for helping our son'. You're not doing it for the thank yous. I kept thinking you're losing your son here and you're still able to say thank you. You can't believe that they were able to be so nice in such horrible circumstances.

There is subtle evidence that Elizabeth calls upon her past experiential learning when she recalls the time she has been in the caring profession (*"I have been nursing for quite a few years now"*). She refers to the time spent in different caring roles that help her deal with clinical situations as they arise in her present practice: her experience over the years (although she has been nursing in a different capacity) has equipped her with relevant skills that she can call upon in different situations (*"I have dealt with a lot of things"*). Benner (2004, p.188) refers to a person experiencing events and using their experience in differing circumstances as applying 'techné'. Although Elizabeth has found her previous experiences within practice helpful, she highlights that sometimes the unexpected reactions to encounters can be a source of surprise and emotional labour (Smith & Gray, 2001). When Elizabeth says *"but recently I dealt with something that completely knocked me"*, she is referring to learning while in a practice situation; she is confirming that learning over time has helped her deal with similar but differing situations as they arise (Benner, 1982). Benner (1982) refers to the personal emotional challenges that student nurses face when dealing with illness as being distinctive from those of other professions and those that lay people are likely to meet. The emotional challenges differ in their intensity and frequency, as the nature of the profession means that nurses are likely to meet distressing and emotionally challenging situations every day. Benner (1982) and Dreyfus (1981) say that controlling and reacting appropriately to emotional situations is a learned skill. Although each situation is unique, past learning experiences can be brought into the present, manipulated to the

benefit of both the nurse and the person needing help. Elizabeth appears to be agreeing with these thoughts. She herself was surprised at her reaction to a very difficult and emotionally challenging situation, one that she had not met before. Elizabeth is saying that although experience helps her deal with present emotional situations, it cannot prepare a nurse for every event they deal with. To make the point of how difficult she had found the occurrence, she repeats and emphasises the words "*It really knocked me*". In Elizabeth's view, experience therefore cannot always prepare a nurse for what they might face. The implication of this is that, professionally, Elizabeth might need to call upon coping mechanisms such as double-faced emotion management to act in a way that is expected (Hayward & Tuckey, 2011).

Elizabeth turns her attention to the family of the patient, the family "*who were completely unaware of their situation and they came to A&E*". There was an immediate and profound human interaction between Elizabeth, the family and the patient ("*I could see their distress*"). This encounter with the family led Elizabeth to experience and show a deep and empathetic understanding of the trauma that the family were experiencing; she was sensitive to their emotional state (Sheehan *et al.*, 2013) and recognised the immense distress of the family (Miller, 2002). The empathetic response transcended to one which she shared with the family. Elizabeth displayed the traits of cognitive empathy rather than the traits of emotional empathy (Hojat, 2009). Although she appears to feel what the family were feeling, she also uses her empathetic ability to comprehend their mixture of emotions. She captures their plight, recognising their emotional turmoil and acting in the appropriate emotional manner demanded of her role (Hochschild, 1983). Putting their "*living hell*" before her own emotional responses, her immense sadness and despair at the unfolding scenario were superseded by providing compassionate care for the family and the patient. She sums up her feelings surrounding the scenario as she says "*I felt distressed*". The distress and responses that Elizabeth demonstrated appear to both support and contradict Smajdor (2013). It supports what she says in the fact that Elizabeth does not really know the family or their son, yet performs caring tasks that are required in that situation. However, in contrast to Smajdor Elizabeth's words and actions prove contradictory. Elizabeth is feeling and

demonstrating emotions such as compassion, distress and sadness in a short time without fully knowing the person.

In the next part of her narrative, Elizabeth highlights the importance of communication in situations that invoke emotional responses: as she says, *“At every opportunity, when we had their son settled, we would bring them through to discuss what was happening ensuring that they knew”*. It was imperative in this atmosphere of the family’s distress that Elizabeth and her colleagues elicited and shared personal information to complete the history of both the family and their son in order to help them both. Howe (2013) says that this sharing of personal information allows a deeper understanding of personal suffering and helps tailor empathy to those agonising. Although this appears to be in direct contrast to the thoughts of Smajdor (2013), who suggests that there is not a need to know a person to deliver effective care, the points Smajdor makes would be applicable when a healthcare professional is unable to gain relevant information. Otherwise, helping someone who is suffering and needs care requires more than knowing, more than using one’s intuition of what the principal cause is, as sometimes the hidden details prove invaluable (Rosenberg & Gallo-Silver, 2011; Kohut, 1977; Howe, 2013). The gaining of the family’s trust and cooperation was paramount in what was a limited amount of time. Trust enables survival: trust in this case needed to be established almost immediately to not only help the family with their distress but also help their son to survive (Erikson, 1965). Elizabeth recognised the importance of effective communication: as she said, *“it was so important that they knew and we got information as well”*.

What happened next Elizabeth found difficult to understand, as the family verbalised their gratitude for the help that she and others were showing to their son (*“they kept saying ‘thank you’ ‘thank you for helping our son’”*). To the family there is an importance to saying thank you: they needed to show their appreciation and gratitude for the compassion that was being shown to their son and to them. Saying thank you is one of the most important ways of interacting and demonstrating gratitude, and is known to be a motivator (Grant & Francesca, 2010). At this point Elizabeth thinks that the family’s needs are more important than her own; she does not need motivation to do what she is doing – concentrating her compassionate love to help them.

Elizabeth's view is that their needs took precedence over hers at this point (*"You're not doing it for the thank yous. I kept thinking you're losing your son here... You can't believe that they were able to be so nice in such horrible circumstances."*) Underwood (2008) says that compassionate love centres on the good of another and in this case Elizabeth was putting the family's needs before her own, confirming that sometimes compassionate love benefits the recipient more than the provider.

Elizabeth elaborates on the above event:

His mum asked me to hold his hand when she wasn't in the resus with him. I get all upset thinking about it. I held his hand, I was like a surrogate mum to him in those few hours. I moved away when his mum was allowed in. I kept thinking about my son, he's about the same age as their son was. I wish I could have done more. He went to ICU [Intensive Care Unit], my friend looked after him there, I knew he was being well cared for.

Up to this point Elizabeth's account refers to the involvement of the family and gives the impression that both parents were present together as there has been reference to *"our son"*. The focus now changes and in the moving account that follows Elizabeth captures the thoughts of a mother who was desperate to look after her son in a horrendous, life-threatening situation: she is fighting for her son's survival. This reciprocal bond, this attachment between child and parent, has been referred to as the 'caregiving system' (Bowlby, 1969/1982; Kringelbach & Phillips, 2014). This is a set of behaviours designed to help protect and give support in times of need; it helps improve survival and in evolutionary terms protects shared genes (Mikulincer *et al.*, 2005). It was this system that had been activated within the mother to care for and protect her son. However, because of circumstances the caregiving system had become disorganised, and the mother felt unable to stay with her son at all times. In the disorganisation and helplessness that occurred, the mother perceived herself unable to protect her child and so did the only thing she could: she asked Elizabeth to step in and replace her when she could not be present. This verbal request as well as the sight and presence of a mother in need activated Elizabeth's caregiving system. She took an empathetic perspective to try to reduce the suffering that she was witnessing; she overrode her own emotional responses. As Mikulincer *et al.*

(2005, p.818) say, “the caregiving system is focused on the other’s welfare and therefore directs attention to the other’s distress rather than to one’s own emotional state”. With the mother’s permission and indeed at her direct request (“*His mum asked me to hold his hand when she wasn’t in resus with him*”), Elizabeth by proxy stood in to provide the care and protection usually associated with the intimate and usually unique mother’s love for a child. Bowlby (1969/1982) has referred to harmonising systems that may originate from the support seeker’s (the mother) needs that in this case activated Elizabeth’s caregiving systems. Elizabeth realises that this transferring of care to a proxy carried immense responsibilities: that she was for short periods “*like a surrogate mum to him in those few hours*”. Elizabeth has been placed in and seen by the mother to be in a caregiving role that complements attachment behaviour. Elizabeth realises that she is intermittently adopting the role of the primary caregiver, to be there when needed and to intervene judiciously should it be appropriate (Bowlby, 1988), yet she “*moved away when his mum was allowed in*”. There is evidence that Elizabeth realised the profoundness of this responsibility and could associate with the mother’s pain (“*I kept thinking about my son, he’s about the same age as their son*”). She is fully immersed in the emotional pain of the mother: as a mother herself, she imagines and perceives what it could be like if it was her son that was the patient.

Although suffering emotional pain, she appears to be using double-faced emotion management so that she can function in her role as a nurse (Hochschild, 1983). This management of emotions appears to be both deep layered and surface acting, as there is little doubt she is in distress, yet has to and wants to function and perform the duties that are expected and at this time needed within the role (Hayward & Tuckey, 2011). She ends this part of her story by saying that he (the patient) transferred departments to continue his treatment (“*He went to ICU*”). Elizabeth perceives that she has some responsibility, some attachment to him, even when transferred out of her immediate care, a responsibility and attachment that was significant and had developed over a matter of hours. It was important that somebody close to her, somebody that she appears to trust (“*my friend looked after him there, I knew he was being well cared for*”) was taking over, continuing the high

standard of care that she initially provided (Macmurray, 1961; Austin, 2005). It appears that she monitored his progress. Elizabeth felt responsibility: her attachment, care and compassion towards her patient did not end when her “*surrogate son*” left her care.

6.6 Learning in practice

Continuing to discuss the scenario, Elizabeth spoke about the value of experiential learning in practice:

If I come across it again [referring to the scenario above] I probably won't be as upset because you have dealt with it before, even though it will be somebody different. Not that you become hard, you just get it, you learn to deal with it a bit better. I don't want to sound awful, it was awful but you can move on from it and learn from it, take it in, deal with it and take it forward.

Experiential learning occurs through a process that involves participation (Wenger, 1998; Lave, 1998; Yuki, 2006; Bray *et al.*, 2014). This learning experience enabled knowledge inherent or otherwise to be placed into a context which was meaningful to Elizabeth (Benner, 1982). Elizabeth says that in future she “*probably won't be as upset because you have dealt with it before, even though it will be somebody different*”. This supports the thoughts of Hayward and Tuckey (2011) and Benner (1982) who say that previous experiential learning can be manipulated to present and evolving situations. There is a profoundness in the words Elizabeth uses about the bridging of theory to the realities of practice: Elizabeth acknowledges that she learned from a distressing and emotional situation (“*you just get it*”), consolidating her theoretical knowledge with the practicalities of practice. She is aware when she says “*you learn to deal with it a bit better*” that learning is a continual process (Hojat, 2009; Egan, 2010).

There is underlying embarrassment that she has learned from such a distressing occurrence (“*I don't want to sound awful*”). Benner (1982), referring to the emotional challenges associated with nursing, talks about the distressing situations nurses are confronted with, situations that are not commonly encountered by lay people, situations that lay people may find it abhorrent to learn from, yet Elizabeth does “*deal with it*” and proposes to “*take it forward*”. She is able to take what was a negative experience for

herself and the family, and turn it into a positive to help support others and herself (Myers, 2004).

Elizabeth continues to talk about the scenario, but I began to appreciate that another theme was emerging from within her narrative: she began to relate albeit briefly to communities of learning in practice:

That day was just one example of how we all worked together on that ward. The doctors, nurses, everyone, we complemented each other. We worked so hard to save him, it was like we were one, we all fought so hard. You learn from the situation, nothing can take the place of learning in practice. When you're in practice, working there, you put into place what you have learnt in lectures. Practice matters, real life and I don't think that any role-play or lecture could have prepared me for what happened that day.

Elizabeth was on a clinical placement whose ethos was that different healthcare professionals worked not only within their professional capacities, but seamlessly and without professional boundaries and “*complemented each other*”. This way of working is in contrast to when professionals practice within an enclosed community bound by their own identities (Goode, 1957; Gobbi, 2009). This was not the case within this placement as everyone “*worked together on that ward... it was like we were one*”. There is evidence of all three dimensions that Wenger (1998, p.73) refers to as instrumental to a CoP; mutual engagement, a joint enterprise and a shared repertoire. This is evident as all the staff are working seamlessly towards one goal, saving the patient. Elizabeth indicates that all the staff were drawn together and defined by knowledge and attributes rather than task (Wenger, 1998).

Elizabeth is a student working within a CoP and therefore could be referred to as an apprentice within a situated learning environment; learning through participation within a set community (Nightingale, 1860; Lave & Wenger, 1991; Wenger, 1998; Lave, 1998; Gobbi, 2009; NMC, 2010). Although technically an apprentice, she is going beyond what is normally expected of a learner. Elizabeth is experiencing, demonstrating and being regarded as a fully immersed member of the community. She is taking a leading role in the care of the son and has been identified by the mother as a substitute caregiver. These leading roles are usually associated with and undertaken by qualified staff. Elizabeth is contradicting the work of Lave

(1998) who says that by their very status students do not hold as much command as permanently established staff. Elizabeth is being viewed as a fully established member as she takes a leading and principal role in the scenario. This may be due to her previous life experiences, knowledge, learning and understanding, which she has the ability to contextualise within an experiential framework (Lave and Wenger, 1991).

The seamless working and the benefits of experiential learning and consolidation are highlighted within research into nursing identities and communities of practice (Burkitt *et al.*, 2000). The report concluded that CoPs provided a channel in which to reify nursing theories and evidence-based practice through participation alongside other healthcare professionals. Elizabeth supports these thoughts: in saying “*nothing can take the place of learning in practice*”, she is suggesting that what has been “*learnt in lectures*” needs to be consolidated within the practice arena. Dreyfus and Dreyfus (1986) and Wenger (1998) confirm what Elizabeth says when she indicates that what she learns within practice cannot be taught to the same level in other learning environments. The contextualising of theory within practice produces a deeper understanding for Elizabeth than when merely taught (Edmonds-Cady & Sosulski, 2012).

6.7 Learning compassion within the university arena

Elizabeth continues on the theme of learning about compassion and applying it to her practice. Her attention is turned to the methods employed within the habitus of the university and focuses upon the use of role-play:

We are taught and learn about compassion and use role-play to learn about it. Learning about compassion and learning from role-play isn't as good as learning from practice. Thinking about it now, as much as it is a false situation it can add to your confidence. It does make you feel that you are not going into situations blind. It's unrealistic with your friends and colleagues on the programme, but it does help you when you come across it in real experience. You wouldn't exactly do the same, you would tailor it to suit that situation. But you feel that you have run through this, you have done about this. I feel a little bit better.

Elizabeth begins by saying that she has been taught about compassion and used “*role-play to learn about it*”. This is a positive comment

acknowledging that it is of benefit and supports her learning experience. She then puts a value on the benefit of role-play, placing it below the learning experience that experiential learning in clinical practice affords. At first her words about the value of role-play are quite negative (*“Learning about compassion and learning from role-play isn’t as good as learning from practice”*). Her initial thoughts, wrongly, appear to place role-play in the traditional surroundings of a lecture theatre, associating that although theoretical principles can be taught via a traditional lecture where little or no interaction is expected, it does not mirror the actual experiences of learning in practice (McCaugherty, 1991). Her initial thoughts, however, change quickly and she expresses a less negative opinion about role-play: *“Thinking about it now, as much as it is a false situation it can add to your confidence. It does make you feel that you are not going into situations blind”*. Elizabeth’s opinion is that role-play, although not truly authentic, increases her self-confidence and she is able to use the experience to increase her affective domain skills that she can use within clinical practice. Emotive learning is important as emotional experiences achievable through role-play help store knowledge in memory (Clapper, 2010). The experiential and emotive learning that occurs within role-play lays the foundation for experiential learning away from and without the challenges and stresses of clinical practice (Babatsikou & Gerogianni, 2012). Elizabeth finds this method of learning beneficial to her in a professional capacity, increasing her skills and knowledge (*“it does help you when you come across it in real experience”*). She continues to indicate that, although not a perfect way of learning what might occur in practice, it does pre-empt to some extent ‘real life’ events. She concludes this part of her narrative positively and suggests that this method of learning is of value (*“But you feel that you have run through this, you have done about this. I feel a little bit better”*), suggesting that role-play is helpful in preparing her for practice.

6.8 Summary of Elizabeth’s story

Elizabeth tells a story and she begins by voicing what compassion looks like to her, and that other people may view compassion differently. She uses emotions and feelings interchangeably to describe her experiences when

looking after a person. She says that compassion is activated by seeing a person in distress. Seeing a person that needs help activates her emotions and she tries to get to know the person, to understand them and deliver the care that they need in a manner that they want. She thinks that by getting to know her patient she can view their problem from their perspective and act appropriately, and believes that this is based upon a successful and reciprocal relationship. At times, she feels that if the relationship is not reciprocal she will give the care altruistically and to the best of her ability.

When caring for a person she associates the compassion she shows with the care that she provides to her immediate family. She demonstrates strong family attachment traits that she attributes to her loving and caring family. She is able and wants to demonstrate compassionate love to those people she cares for. She says that her experience of being a patient and receiving help led her to a deeper understanding of how to meet her patients' needs. To demonstrate the depths of her compassion for others she describes a moving scenario that describes relationships that develop between her, the patient and the patient's family. It was in this distressing scene that Elizabeth was asked by the mother to be a temporary surrogate to her son as they battled to save him. Elizabeth was deeply moved by this experience, and showed signs that she was emotionally challenged and adversely affected; she experienced emotional labour.

Her narrative moves her on to describe how she learns about compassion within both clinical practice and university spaces. She suggests it is within clinical practice that she learns how to treat people compassionately. She finds that practice placements that display a CoP philosophy help support her learning; moreover, it improves the care provided to patients more effectively than those clinical areas that use a team approach.

Turning her thoughts to compassionate learning and teaching within a university environment, she says that to her, it is not as effective as authentic experiential learning within practice. Yet she does talk about pedagogical benefits of role-play through experiential learning that helped improve her confidence when she was later within the placement setting. She has found her learning about compassion in the university setting helpful, and can now

manipulate what she has learned to address what she witnesses in practice. Experiential learning about compassion with the university setting does appear to benefit Elizabeth.

Chapter 7: David's Story

7.1 Personal introduction to David

David is probably the participant that I know least about and have had least contact with. This is because David's focus is on the field of mental health (MH). (All of the participants are on a programme where they have undertaken a common foundation in the first year before branching off to focus on their specific field of nursing.) David thus provided an opportunity to investigate if there were differences in his perception of compassion arising from his MH nurse perspective. Because David is a MH student, after his first year he attended another campus for his academic teaching, only coming back to the campus that I am assigned to for a few generic modules of which I am not a module leader. I did teach David in his first year, mainly 'skills for practice' but that was over two years ago. I knew about his background because I make a conscious effort to try to know a little about all of the students that I teach. David's background was in building construction: he had been a bricklayer before going into caring and becoming a healthcare assistant (HCA) within MH services. After four years of being a HCA he was given the opportunity through secondment to train as a nurse, an opportunity that he said he 'was lucky to be offered'.

7.2 David's definition of compassion

David began his narrative by describing his definition of compassion:

I think it's around feelings, it's about putting your feelings into use and that you're caring for somebody, it's how you use your feelings looking after somebody that needs your help, but they have got to want it though. I still look after them, think that's it's kind of a part of our role as a nurse. I know that there is different views of it, you can't really learn it, and I believe that it's inherent, it is kind of inherent it is a human attribute. It does need to be explored in a person sometimes, it might take something to happen in a person's life that may trigger somebody's compassion, maybe they don't have compassion before this happens, well they do have compassion, they just haven't shown it or used it. They take a step back and they think maybe this is compassion. It could be the way that they are brought up so they haven't come across it, they don't know that they have this as an attribute, but then something happens, everybody has an ability to be compassionate.

David starts by describing compassion as being based upon "*feelings*". It appears that David is using the word "*feelings*" to describe the emotional empathy that he experiences, at times using the words feelings and emotions interchangeably (Purdie *et al.*, 2008). David is aware that the feelings he experiences are a result of a stimulus such as seeing someone in need ("*somebody that needs your help*"), and when David witnesses distress it affects him and he becomes empathetic to the person; this then acts as a precursor that stimulates the emotions he experiences. David thinks that these feelings can be utilised to help people and he draws upon them to help him make nursing judgements: as he says, it is about using these feelings to help care for people ("*somebody that needs your help*"). By using the feelings and emotions, it becomes a conscious decision on whether to act or not as judgements require conscious consideration; his feelings change from emotional to affective empathy. By appraising the feelings and emotions that he experiences he is able to sensitively and thoughtfully prioritise actions required of him to optimise the situation (Hayward & Tuckey, 2011).

David does not consider himself unique in his ability to act upon his emotions as throughout this part of his story he directs his thoughts towards third parties. He suggests that he thinks other people can also exploit feelings and emotions. This is evident when he says "*it's about putting your feelings into use*"; by 'use' he means the overall actions of a person that contribute to the quality of caring and considerate actions.

7.3 The reciprocal nature of relationships in practice

David believes that an important factor for compassion to occur is the consent and agreement of the person it is directed to ("*they have got to want it though*"). Compassion to David is reciprocal, and he thinks that it is more than him providing care in a task-orientated way. He highlights the importance that he places on the relationship between the patient and himself if he is to demonstrate caring in a compassionate and attuned manner (Sprecher & Fehr, 2006). He believes that patients' need to want and be accepting of care in an emotional person-centred way if compassionate caring is to take place, and that patients have the choice to accept or rebuff compassionate caring acts that are offered. The choice might not be as

straightforward as it appears: Bifulco and Thomas (2013, p. 237) argue that some people's ability to accept compassionate acts has been influenced by their emotional experiences of rejection as children. The effects of rejection (usually by their main carer) go on to affect their adult emotional resonance; emotional resonance that has been influenced by experiences outside of their control. A person subjected to rejection as a child may develop traits that have significant consequences, resulting in their inability to engage in emotional relationships. The traits have been categorised by Bifulco and Thomas (2013, p.237) as anxious, avoidant and anxious-avoidant.

David has highlighted the far-reaching effects that the lack of reciprocity can have and that it can be problematic for compassionate practice. It also means that compassionate caring has to be demonstrated not only on individual needs, but also after due consideration of how the person will perceive and accept the compassion that is offered. If correct, then a person's disposition will have a direct influence on whether they want to or can accept help. Their disposition will also have an effect on David's ability to attune with them, to personalise their care in line with his wishes.

Siegel (2007a; 2007b, 2010) says that attunement occurs through getting to know the patient, usually through conversational two-way encounters, and is based upon reciprocity. Attunement within healthcare is believed to be central within a therapeutic and mutually benefiting relationship, as it enables care and the way it is given (moulded around a person's preferences, wants and needs). When these thoughts were applied to what David said, he disagreed with this point: in his words when people are not acting reciprocally, he can "*still look after them*". By "*looking after*" somebody he is referring to carrying out certain treatments, not referring to the way he feels or the patient feels when he is carrying them out. David could be acting compassionately, but adjusting the way he delivers the care so the patient does not feel uncomfortable; compassion therefore becomes veiled. On the other hand, he could be saying that good care does not have to be given compassionately, just effectively. This thought that effective care does not have to be compassionately given is characteristic of Smajdor's (2013) theory. Referring specifically to nurses and the delivery of effective care, she says "compassion is not a necessary component of healthcare, since the

crucial tasks associated with healthcare can be carried out in the absence of compassion” (p.4).

7.4 The inherent nature of emotion

David suggests that compassion cannot be learned but is an inborn quality (*“I believe that it’s inherent”*), and that some people do not use it, do not know that they have or own it as a personal characteristic that they possess. He thinks that some people are not aware that they are compassionate until they experience a situation that awakens or acts as a “trigger” to expose it, at which point they experience the feelings and the emotion of compassion (*“It needs to be explored sometimes”*). . What David is describing can be associated with the evolutionary theory of Darwin (1872/2007) who claimed that emotions are inherent and have evolved to protect not only oneself but safeguard significant others. Darwin thought that compassion is an affective state that enhances the chances of survival of the vulnerable and enhances cooperation within and across societies.

At the end of this part of his narrative David contradicts, but quickly corrects, what he has said previously. In reference to an emotional experience preceding a compassionate response, he says *“maybe they don’t have compassion before this happens”*, which contradicts his previous thoughts that everyone has the ability to be compassionate and that it is inherent. He corrects himself immediately, saying *“well they do have compassion, they just haven’t shown it or used it”*. David’s thoughts are succinctly brought together by theories of attachment in relation to caregiving. Bowlby (1969/1982) built upon Darwin’s evolutionary theory and suggested that the ability to attach to and care for another human being has also evolved to improve survival. Within the attachment trait argument it is thought that compassion activates the affective part of the caregiving system. This activation is usually first noticeable between a baby and their caregiver which is a reciprocal response where the ultimate aim is to protect the child. The caregiving trait is known to be present in some situations that occur between adults, and can be awakened by sensory prompts; as Bowlby (1977, p.133) says, “The behaviour of parents, and of anyone else in a caregiving role, is complementary to attachment behaviour.”

David signifies that although he thinks it is an inherent trait, the person may only know or become personally aware of the feelings that compassion holds, when a life event effectively awakens this inherent emotion ("*They take a step back and they think maybe this is compassion*"). David makes two points here: one reason for some people not demonstrating or knowing that they have compassion as a personal attribute, may be that they have not been the recipient of compassion or grown up in a compassionate environment. Howe *et al.* (1999, p.10) theorise that the environment and the experiences that a person has been exposed to affects their worldview and how they are able to behave within the society they operate in. They also say that these experiences impact upon attachment and caregiving traits in a person: "Later on, the understanding and display of emotions begins to take note of others' affective state and the social context in which interpersonal life takes place". Based upon role-modelling, a person's experience of caregiving throughout their childhood affects their attachment traits either positively or negatively throughout their life continuum. The theory that Howe *et al.* (1999) present is also reflected in the work of Kringlebach and Phillips (2014) who say that the role-modelling that a person has been exposed to as a child can affect an adult's ability to give care to others. If as a child they have had negative experiences of caregiving, they will find giving care to others challenging; while positive experiences of caregiving as a child can result in an adult who feels comfortable as a caregiver whose reach can transcend the immediate family. Kringlebach and Phillips (2014, p.108) in reference to attachment theory say: "With the development of a theory of mind comes the ability to show compassion or experience empathy". The development of attachment traits may transcend to the person's personal abilities to give and receive care throughout life. If this is right then this theory will affect not only nurses in their role of caregiver but the patients' willingness to accept care.

David's second point could mean that people become aware of or change their attachment styles, attachment traits and their personal role through the effect of adult experiences. By taking on the role of what is expected of a student nurse, the students are also taking on a role that may be new to them; the role of an attachment figure, someone (in this case) who provides

care and acts appropriately when they see distress. Bifulco and Thomas (2013) think that for adults close figures such as friends and partners become attachment figures, taking the place of the close carers within childhood. When this theory is applied to the relationship between patients and nurses, it is the patient who requires the nurse to take on the caregiving role: patients view student nurses as an attachment figure. The ability for a person to adapt to different attachment traits in adulthood supports Bowlby's (1980) argument. Bowlby (1988) changed his original thoughts that a person's attachment trait was static, established in childhood, to the thought that attachment traits are a flexible concept that may change throughout life and be affected by experiences. Therefore, the differing experiences of being a student nurse could influence personal attachment styles.

7.5 Family attachments

David added to his thoughts that emotions, family and family attachments emanating from childhood experiences affect perceptions of compassion and the ability to be compassionate:

I think that things happen to a person in their life and it could start as a baby, things happen whether it is a learning experience or just a feeling, things happen that brings compassion out of you. I've been lucky, I've had a great upbringing. I'm sure that it has helped, I can relate to people, I'm not scared of showing my emotions.

In this part of David's narrative, there are subtle references to what he has insinuated previously. He refers to the relationships that he formed in younger life and how they have affected him as an adult and as a nurse: "*I think that things happen to a person in their life and it could start as a baby, things happen whether it is a learning experience or just a feeling, things happen that brings compassion out of you*". David suggests that as children we learn from experiences and learning continues throughout life ("*it could start as a baby*"). As adults we look back on those experiences and they have an effect on who we are and the nature of our emotional disposition as adults. An important point that he also makes is that different experiences as an adult can change the way an adult views and demonstrates compassion ("*things happen that brings compassion out of you*"). What he says is

supported by Clarke and Clarke (1998) who built upon Bowlby's (1998) theory regarding early emotional and cognitive development in children and its effect into adulthood. They said that children who were exposed to less than favourable environments that negatively affected their emotional and cognitive development could recover; changes to their emotional and cognitive resilience would occur if they were exposed to favourable experiences, and these changes could occur throughout life. Clarke and Clarke (1998, p.435) explained that emotional adversity suffered as a child is less buffered and harder for a person to recover from than any cognitive adversity that a child encounters, yet David refers to "*things that happen*", experiences that as an adult can positively affect the person's ability to demonstrate compassion.

David conveys the views that his upbringing was favourable and that this has had a positive effect on him, facilitating the fact that he is not only able to connect or as he says "*relate to people*", but is not afraid of the sentiments which he thinks that you need to demonstrate compassion. His ability to relate to people and not being *scared of "showing my emotions"* are what Bifulco and Thomas (2013, p.9) say are characteristics allied to secure attachment traits. He is confident within close relationships and is able to empathise. He does, however, think that there is a professional boundary to how he demonstrates his emotional resonance with patients and their families.

David went on to talk about his view of emotions and their professional boundaries:

*I keep my emotions professional, I try to help, but you know?
That can be hard especially when you get close to a patient
and their family.*

Emotional connections and rapports are common in the nurse-patient relationship as nurse-patient interactions occur that are of an intimate nature. David says that it "*can be hard*" to control his emotions in this way and "*especially when you get close to a patient and their family*". David finds some of his nursing work emotionally challenging. Hochschild (1983) suggests a theory about a person managing or regulating their emotions that combines the inherent biological approaches of the Darwinian theory of

emotion with the effects of an individual's social life experiences. Applying it to nursing, she suggests that nurses are expected to manage their emotions when caring for patients in order to "sustain the outward countenance that produces the proper state of mind in others ..." (p.7). This is what David appears to be doing, as at times he finds it challenging for him to control his emotions; but he says it is even harder for him to manage his emotions and maintain his professionalism when he becomes emotionally involved and develops an intimate relationship with a patient and their families. He appears to be consciously aware that his emotions are intensified as he gets to know his patients and their families, and he finds them harder to subdue. But subdue them he does to provide compassionate care, the needs of his patients and their families taking precedence over his own.

In subduing his emotions, David also appears to have developed the ability to regulate his emotions by using deep acting as opposed to surface acting. Hochschild (1979, p.561-2) theorises that in surface acting an individual pretends to feel and display what is expected of them in a situation, in contrast to deep acting where a person lets their feelings their emotions form the basis of "acting" or impression management". David appears to use deep acting as a ploy to align his behaviour with what is expected of him as a student nurse.

David then turns his attention to how he feels about his family and how he applies what he feels for his family to patients in his care:

I'm very close to all my family, yeah, I can say we love each other. When I look after people I think about how I would want my family to be looked after.

He uses the word "love" in relation to what he feels towards his family members. Although he does not use this word specifically when relating to what he feels towards patients, he does relate that the standard of care that patients should receive should be comparable to the way that he would want the family that he loves to be cared for ("*I think about how I would want my family to be looked after*"). Sprecher and Fehr (2005, p.629-630) refer to this type of love as "compassionate or altruistic love that can be experienced for a variety of others, including all of human kind". He converts the emotions and the amount of love that he feels for his family members into something

tangible that he can use as a measure; and customises his feelings of love for his family and uses it as a guide to qualify and quantify the standard of compassionate care that a patient should receive. This emotion of compassionate prosocial love motivates David to offer help to his patients.

David's narrative continues to demonstrate his perception of the impact of familial terms of endearment in relation to attachment theory and the theory of compassionate love. He recounts:

Sometimes older people call me son, come over here son, can you help me son? While younger people sometimes call me bruv. I'm not sure if they mean son or brother and are just calling me that instead of my name, coz they don't know it or they have forgotten it or just because I remind them of their son or brother, does that make sense? Anyway that's not a problem, it's quite OK, I know I can't, I don't want to anyway, answer them back in a similar way, that wouldn't be right, that wouldn't be professional.

David says that sometimes to get his attention "older people call me son, come over here son, can you help me son? While younger people sometimes call me bruv, can you help me bruv?" These familial, symbolic terms of endearment are perhaps a generational phenomenon. The older and younger generation believe that it is acceptable to employ these terms when they do not know his name. Patients can meet many nurses during their stay in hospital, so it is not unusual for them not to know or to forget the names of nurses. There could be another reason why patients are using familial terms that may indicate that they have a deeper emotional reciprocal attachment to David. The patient, if they wanted to, could just use the word 'nurse' to attract David's attention but they don't, they decide to use a word that has the connotation of an intimate and close relationship. The word 'son' or 'bruv' implies that they have formed a relationship which can be viewed as akin to those in family attachment and caregiving theories. When they need David's help, the patients are using these close and special references to activate David's emotional attachment and his family systems caregiving traits. This symbolic use of familial names is associated with the work of Mikulincer *et al.* (2005, p.818) who say that the caregiving system is closely associated with the attachment theory suggested by Bowlby (1969/1982). Both theories merge when they both suggest that family attachments and

caregiving systems are considered to provide protection and help to members of society who are in need.

7.6 Learning about compassion

David continued his narrative, turning to the experiences to learning about compassion within the university setting. This part of his narrative was both short and succinct:

I think it links indirectly with skills. We did a lot about application scenarios through role-play and you get to think about things in scenarios before you go into the real world. It helps with communication and our emotions. I think it does help but nobody likes doing role-play, it does definitely help though. The best experience of learning compassion you can have is being in practice.

He remembers that compassion was addressed in three ways within the university teaching space. According to David it was merged into the acquiring or practising of “skills” and was addressed with “application scenarios” and “role-play”. He thought that role-play did what it was supposed to, it enabled him “to get to think about things... before you go into the real world”. What David is saying aligns to the theory of Clapper (2010, p.41), that role-play is effective in generating the experiences and the emotions that a student nurse might feel and “that exist in real practice”. The role-play that David was involved in proved successful in what it is designed to do: imitate the interactions that occur between nurses and patients within a safe environment, away from the authentic setting of clinical practice.

David thought that this was achieved through skills practice. He was referring to simulation through the medium of role-play, which is thought to be advantageous in helping learners to consolidate learning through experiential learning. Through authentic scenarios, students are able to learn from each other the feelings they can expect; David refers to this as being given the opportunity “to think about things”. David is, as Benner (2015, p.1) implies, receiving the “theoretical and knowledge base” that is expected within the profession. This experiential learning and knowledge has the potential for crossing the boundaries of learning spaces within the university and being utilised in clinical practice. Thinking about things gives David time to consolidate, reflect upon and make sense of his experiences. He is able to

scaffold his learning and contemplate how he would approach similar situations within clinical practice.

“I think it does help but nobody likes doing role-play”. Here, David is explaining that the general feeling of those participating in role-play is negative, yet he thinks that it is beneficial to learning. He is expressing that students can feel quite vulnerable and awkward when taking part. For it to be of optimum value to students they need to become actively involved; this demands imagination and willingness on their part. Edmonds-Cady and Sosulski (2012) suggest that only when students become immersed do they fully benefit from the experience; David indicates the students are not as fully immersed as they might be. Even so, he still thinks that it is beneficial (*“it does definitely help though”*).

Not giving any further details about his views of learning through role-play within the university setting, he quickly and fairly abruptly turned his attention to how he is able to apply knowledge to not only ‘learning’ but ‘experiencing’ compassion within clinical practice. His last sentence in this part of his narrative was powerful and said with no hesitation, no doubt: *“The best experience of learning compassion you can have is being in practice.”*

In the next part of his narrative David briefly refers to learning within the university setting before he talks about his experiences in clinical practice. The experiences which he related to occurred on one clinical placement, a mental health ward that was a base for treating elderly people who have developed dementia and memory problems. He said:

Experience, uni, I would say changed my view of compassion, it helps when I get out there. I also think my experience in practice made me more compassionate to certain client groups, all groups now, everyone that I look after. I think it's the life experience of being in that situation and being faced with the situation. It helps in developing the role and that you're also developing as individuals.

David confirms that “*experience, [in] uni*” has had an effect on him, using the expression “*uni*” as an overarching term for learning within the pre-registration programme. David is referring to two benefits in relation to experience: firstly, to the benefits that come with acquiring cognitive affective knowledge within a university setting, and then to the positivity of experiential

situated and authentic learning (*"experience in practice, it made me more compassionate"*). David is explaining that experience has enhanced his compassionate persona. This fits with Benner's (1982, p.402) theory that experiential learning within the pre-registration nurse programme's theoretical education and clinical experiences helps achieve affective professional traits expected of a nursing student and qualified nurse.

David has previously expressed that he believes that he has always been compassionate, so it can be assumed he was compassionate upon entry to the programme. David is now saying that in some way his views, his experience of compassion, have intensified and made him *"more compassionate"*. David's learning experiences within the programme through skill acquisition and theoretical knowledge have positively influenced his progression towards being an expert compassionate nurse. It appears that he is saying compassion can be enhanced, internalised and synthesised into particular situations as part of the taught elements of the programme. He is able to apply this acquired knowledge to the experiences that he encounters within practice. It is through these encounters that he consolidates his learning, which results in him feeling that he is now a more compassionate person than before.

In her later work Benner (2015) supports what David says: that the true experiences of compassion that result in deep understanding and meaning can only be experienced in authentic surroundings. However, Benner (2015, p.5) says that knowledge acquired through experiential learning that occurs within university spaces does help students within clinical placements. David agrees, referring to his learning within the university environment when saying *"it helped when I got out there"*, 'out there' referring to his experiences of clinical placements. David is also implying that emotional encounters in an authentic arena have enabled him to use his theoretical knowledge and place it symbiotically into his clinical practice. He is supporting the claim that learning from a theoretical perspective has enabled him to consolidate and locate previously acquired knowledge in his application to practical situations. David in some ways pacifies the fierce dispute within nursing that there exists a theory-practice gap, which has been highlighted in the work of Cope *et al.* (1999), Kellehear (2014), and McEwen and Wills (2014). These

academics suggest that consolidation of learning is sometimes thought to be missing within theoretical acquisition and its application within clinical nursing practice.

David next turns his full attention to situational learning (*"I think it's the life experience of being in that situation"*). The life experience of being in an authentic situation enables a person to construct a reality of what is occurring. David is giving an example of how he is actively applying his life experiences in different and what appear to be challenging situations. It is the authentic nature of practice that facilitates David's learning and allows his application of higher-order knowledge to complex situational experiences. This application demonstrates that he is showing traits associated with experts who are able to manipulate their experiences to fit differing and challenging situations. As he implies, when he is positioned within clinical practice he views it as a learning experience that impacts positively on his professional and personal development, where knowledge acquisition is facilitated through doing and *"being faced with the situation"* (Benner, 2015)

David then expands on his experience of situational learning within clinical practice:

I think that it was the ward as well, it had a different atmosphere, I can't explain it really, every ward I've been on has worked well. It definitely helps compassion be a part of a culture of care if everybody is on board, doctors, dieticians, physios, housekeepers, everyone has to be on board if patients are to get best practice and compassion, it's more than just teamwork, it's moving across professions, it involves everyone.

He refers to a particular ward as having *"a different atmosphere"* and being different to other wards that he has worked in. David is intuitively referring to this ward's particular work environment – the underlying philosophy, the ethos of the ward and how it operates – which appears to be associated with a CoP. This is all but confirmed when in the final part of this section of his narrative, David states *"it's more than just team work, it's moving across professions, it involves everyone"*; this is one description of many that is used to define a CoP. The essence of a CoP is to facilitate learning and expand upon recognised best practice that evolves through a social process of interaction, co-participation and knowledge exchange (Wenger, 2010, p.1).

Although there is a hints of the involvement of CoP in other parts of his narrative, this is the only part in which he refers specifically to the importance of cross-speciality professional working that involves all staff. He values not only the collaborative working amongst professions, but also the role that auxiliary staff have within the community, to work collectively and utilise specific talents within a participational framework. David is saying that valuing everyone's competencies from a non-hierarchical perspective is conducive to developing an optimal working environment.

David suggests this way of working is to the benefit of compassionate and best practice. David experienced situated learning and although he does not go into further detail, it appears that the CoP that he found himself within enhanced this learning experience. He makes the pertinent point that he thinks that one contribution that a CoP makes to the provision of compassionate practice is *"it definitely helps compassion [to] be a part of a culture of care"*. David says that the CoP he was practising in was also a community where compassion and best practice were inherent and nurtured from within. Although he is in no doubt that compassion was nurtured, as was best practice on this ward, David thinks that *"everyone has to be on board if patients are to get best practice and compassion"*. He is suggesting that each member has to have and demonstrate the same philosophy of compassion and best practice if the patient is to receive optimal and compassionate care. Wenger (2010, p.5) calls this collaboration between members of a community "alignment" where a philosophy is agreed upon and followed.

David continues by explaining the effect that this clinical placement had upon his behaviour and his views of compassion, highlighting how this encounter led to him to experience different personal reactions. With an emotive and underlying intensity, he explained that the time spent on this ward had resulted in him both exploring and confronting a different facet of compassion, one he had not previously experienced:

I think that being in that clinical practice is something that has changed and developed me to care more, with more compassion. I'm not saying I didn't have compassion before and there is no set thing that actually happened [referring to his placement], it was the nine weeks I was there that changed me.

I don't know what happened, all I know is that the experiences in that nine weeks changed me and all the people I know would probably say similar things about me. My sister has worked for years in that environment, she said it changed me as well, my friends said I changed, I changed as a person, I changed as a nurse. I've been on elderly care before, but not on a dementia ward, not on an elderly dementia and memory ward. It kind of got me, do I want to go back in to the memory services when I qualify? I didn't before, now I think I might, I'm definitely different. I view compassion and nursing differently.

In this part, David is saying that the experience of this particular practice placement has definitely had a life-changing effect on him, both as a person and a nurse (“[it] developed me to care more, with more compassion”). Over a period of nine weeks, his experience changed his identity and enriched his views and persona. Although David had previous contact with the older generation, the interaction that he had with these patients triggered mixed emotional responses that resulted in a positive experience for David. le May (2009, p.13) has written about the positive effects of patient capital upon professionals within CoP, and says that it can produce “a distinct learning experience”. David has learned from a patient’s perspective, through their world lens, what it is like to live with a diagnosis of dementia. During this new experience, David applied his previous understanding of compassion, enhancing this knowledge and his compassionate practice over a period of time (NMC, 2010).

David indicates that his compassionate qualities were further developed (“I'm not saying I didn't have compassion before”), and that these experiences had enhanced his caregiving system and nurture had a place in altering his worldview. David’s compassionate knowing had been challenged by events, and his compassionate development emerged through conscious experiential learning. The changes which occurred were so profound that they were noticeable by family, friends and colleagues (“she said it changed me as well, my friends said I changed, I changed as a person, I changed as a nurse”). He could not attribute this to any one specific event; therefore, it appears to be a life-changing experience that came from being immersed within the CoP.

7.7 Experiences affecting the compassionate persona

To qualify his thoughts and to emphasise his position that he knew what compassion was before this placement, David continued to expand on his beliefs:

I thought I knew what compassion was and I think that I did know, now, I know a different compassion. It's hard to pin down and describe what exactly happened in the time I was there, but I reflected, it could have been me being scared before going onto that type of placement, I was going onto that placement thinking I was going to be rubbish when it comes to those situations I thought I was going to encounter. I think it's made me definitely better, well hopefully, yes it has made me more caring and compassionate. It's making me more caring in my career because I've got a reference point to situations, although I can deal with tricky clients this kind of experience made me think don't make any rash decisions about not wanting to nurse in different disciplines, and especially not to have preconceived ideas when dealing with people.

David is trying to make sense of the changes that he knows occurred in him as a person within this placement. Before he commenced it, he had a preconceived idea that he was not going to be effective as a person or in his role as a nurse, on that particular ward with that particular clientele who had specific problems related to cognitive dysfunction. As he says, he thought he was going to be “*rubbish when it comes to those situations.*” David had made a negative judgement about himself that stemmed from his inherent personal enigmas, one that was formed before he interacted with the people he had concerns about. These preconceived negative ideas fit with a theory that Bifulco and Thomas (2013, p.288) developed: sometimes therapeutic relationships can be difficult for a healthcare professional as prior “beliefs and thoughts can be challenged”. David had prior negative thoughts about his ability to function within this environment, and his doubtful ability to interact within certain patient groups was frightening to him.

David says that he was “*scared about going onto that type of placement*”. According to Darwin’s (1872/1965) theory of emotions, being scared is an inherent emotion present in humans to help with self-preservation. The feeling of being scared is a mixture of anxiety and fear. He was fearful of the impact that not being ‘good’ within a practice area would have, which then made David anxious. He was both fearful and anxious that his preconceived

ideas would be true, and that he would not perform to a standard that both he and the practice placement wanted. He had an overriding but unsubstantiated fear that he would not do justice to himself or the patients, nor be able to perform the care to the standard that he, the profession and ultimately the patients in his care expected (NMC, 2010; 2015).

Further reasons that David was frightened might include anticipation that he would not cope emotionally, or have the skills required to care for the older person suffering with dementia: sometimes the unknown is more disconcerting than the reality. Within a community of practice, he was able to take what Lave and Wenger (1991) refer to as an active participatory role: a role in which as an apprentice he was able to confront his personal prejudices in a safe and supportive environment.

He is sure that this involvement within this particular placement has helped him within his career, and to understand compassion differently: he has experienced self-realisation. He states tentatively at first, then concludes positively and assertively, that his views on compassion changed during and after this placement for what he perceives as 'the better'. This encounter invoked a different type, a different level of compassion, and substantiates that there are different intensities, different kinds and different components to compassion that are waiting to be discovered within a person: he himself says "*I know a different compassion*".

7.8 Summary of David's story

Within David's case study, he gave a comprehensive and informative description of what compassion means to him. He thought that compassion was an inherent trait that everybody held and that could be activated by emotional encounters. Feelings acted as a prompt, activating emotions that he referred to as compassion. He said that a person might not know what compassion is until they have an experience that activates emotions that they relate to as a compassionate experience. David says that when he witnesses a person in need of his help, it enables him to act to help the person in distress. He thought that it helped him provide compassionate care if a person was able or wanted to accept the help offered, but added that when a person refused his help it did not stop him from reaching out to help

as he felt that providing care was part of his role. He thought it was advantageous for both himself and the patient if they formed a reciprocal relationship as this led to him becoming attuned to the patient's needs.

David placed emphasis on his experiences as a child within a loving family that helped him develop his secure attachment trait in adulthood. He says that he is not afraid of being compassionate to strangers. David thought that although he has always had compassion, his view of it has changed. His compassionate persona has developed since he started the programme, and he has learned through compassionate encounters with patients. This leads him to suppose that a person's attachment trait is not static, but can be influenced by experiences.

When he turns his attention to learning and teaching compassion, he believes that experiential learning was helpful. He said that the use of role-play within the university setting was supportive in preparing him for clinical practice, although he thought it was not as effective as learning from real life experiences when he was caring for patients. He thought that caring for patients affected his beliefs and behaviour, and gave him a deeper understanding of what compassion is. He focused on clinical placements that he had undertaken, and differentiated between wards that took team and CoP approaches. He thought that patient care and supporting students in their learning benefited where the ward adopted a CoP approach. He believed that different learning experiences stimulated different compassionate qualities, which are there waiting to be developed with the help of the right support.

Chapter 8: Critical Reflection on Findings from the Case Studies

8.1 Introduction

In this chapter I critically reflect upon Kat's, David's and Elizabeth's narrative accounts of their personal perception of compassion. In each of the case studies I was able to share their views of how their past and present experiences affect their beliefs and perceptions of compassion. I looked across each individual case to see if there were similarities or differences in the language they used. The students portrayed how they think compassion influences their clinical practice, and how different experiential learning pedagogies within the university setting and clinical practice help them to be compassionate. As I reflected upon what each of the students said, similar themes emerged in their personal accounts. The ideas that they kept coming back to were how emotions feature in the work environment, the effect that emotions have upon them, how relationships evolve, the importance placed upon relationships, and the pedagogical approaches used within the university and clinical practice settings as they navigate their learning. In the following sections of this chapter I summarise the features of their perceptions. I then conclude my study in chapter 9.

8.2 Emotions

Each of the students spoke about the contribution that emotions, feelings and their philosophy of attachment and caregiving systems had upon compassion. In their definitions of compassion, they used different synonyms to describe their personal view, yet the words they chose were used in a similar context to each other. This multifaceted description of compassion resonates well with Purdie *et al.* (2008) who say that it is common for a person to view compassion from their own perspective, and therefore use different synonyms to express their thoughts. The following sentences taken from each student's narrative also support what von Dietze and Orb (2000) say: that student nurses use emotions and feelings interchangeably to communicate what they mean. This is what occurred in the students' descriptions of compassion: they describe similar experiences using different words:

I think it's around feelings, it's about putting your feelings into use, (David)

It's just empathy towards another human being. (Elizabeth)

I just think it's the way you act, I think that involves emotion. (Kat)

It is evident that each of the students is sure that “*feelings*” (David), “*empathy*” (Elizabeth) or “*emotion*” (Kat) have a part to play in compassion. David and Elizabeth chose words that are often used to describe emotions while Kat used the exact word albeit tentatively as she said “*I think that involves emotion*”. Gross and Thompson (2007) talk about empathy being a precursor to a person experiencing feelings, feelings that result in a physiological or psychological response known as an emotion. What is common to the students is that they each state that an event has to occur and that the experience initiates a response that results in them taking action. What they are saying is that when some experience triggers an emotional response, a physiological change occurs within them that has an impact on how they are thinking and behaving (Schachter & Singer, 1962). These changes have an impact upon how they perceive events that unfold in front of them, that have the consequence of them acting in a certain way, which I assume is to alleviate the distress of the person that they are in contact with.

It is through insightful observation that the students try to understand the distress of the patient and this becomes a powerful factor in delivering best care (Rogers, 1975, p.3). The care that the students give appears to be dependent upon how they each perceive the world, the situation that unfolds before them and influences how they react. To perceive the world around them they engage the information that they receive through their senses (Plutchik, 2002). They then cognitively synthesise the information to make reasoned and what they think are rational decisions, trying to understand what actions are needed to alleviate the distress they witness. Their ability to synthesise the information is not only based upon the feelings, emotions and empathy acknowledged at the time, but also their previous experiences supported by reflecting in and on practice (Schön, 1983, 1987). Although emotional reactions appear to be crucial for a compassionate response to

occur, it also appears to support Epstein and Street (2011) when they say reactions to what is happening requires attunement, so that care appropriate to the needs of patients is provided.

Other parts of their narratives expand on their beliefs and their experiences, including whether they view emotions as an intrinsic attribute of being human:

I believe that it's inherent, it is kind of inherent, it is a human attribute... it's how you use your feelings looking after somebody that needs your help". (David)

I think everybody's got it, but shows it differently. (Elizabeth)

I think it is an attitude somebody has towards to somebody who is suffering. This attitude is like feeling what they are feeling. (Kat)

Both Elizabeth and David think that emotions are evoked by intrinsic human mechanisms that result in a person feeling compassionate and acting compassionately (Darwin, 1872/2007). Elizabeth goes one step further by saying that it is not only an intrinsic experience that initiates compassionate acts, it is also the decision(s) that a person makes on what actions to take, based upon how they feel about a situation. Elizabeth appears to be saying that people do not have control over the emotional reactions, but do have control over how they respond to them. Kat has a similar understanding to Elizabeth, but uses different words to describe what she means. She thinks that it is an approach or an “*attitude*”, a reaction that a person has when they witness suffering. She hints that the attitude that someone has is influenced by empathy, saying “*This attitude is like feeling what they are feeling.*” Feeling what another person is feeling is commonly used to describe compassion (Prinz, 2005), though may be described as empathy.

What appears to be the priority in what the students say is not how they describe their feelings or how they describe compassion. What matters is the reaction they or others take: it is the actions taken in distressing therapeutic situations that help relieve the distress that is ultimately important to them.

Yet, compassionate responses appear to be dependent on a person recognising the feelings/emotions/empathy that they experience and responding appropriately to help the patient. It is their “*attitude*” as Kat says,

or how people react. Elizabeth agrees with Kat on this matter as she thinks that different people react differently and that each person “*shows it differently*”. Kat and Elizabeth are indicating that it is a person’s behaviour in distressing situations that is important. If what the students are saying is correct, then the demonstration of compassion is based upon behaviours that a person displays as the result of emotional experiences. This supports what Babatsikou and Gerogianni (2012) and Sheehan *et al.* (2013) say: that a person may be taught about emotions and how to be compassionate. Elizabeth and Kat’s thoughts are complemented by David’s when he says “*it is kind of inherent, it’s a human attribute*”, and support the view of Benner (2015, p.135) that nurses can learn about emotions and learn how to react positively to emotional situations that are unique within nursing.

8.3 Reciprocity leads to attunement

A sub-theme to emotions was the reciprocal relationship that each of the students thought led to being attuned to the emotional and care requirements of patients. In their rich descriptions of reciprocity, Elizabeth and David first referred to the importance of both early on in their stories, while Kat referred to the importance of an attuned professional relationship towards the middle of her story and within her narrative of caring for a patient with a heart condition. What was an underlying factor of reciprocity was trust between the students and the patients they looked after. Trust also led to the students forming relationships that were more likely to be mutually beneficial and lead to reciprocity. Sellman (2006) and Erikson (1965) appear to support what the students are saying, that trust is a factor in ensuring survival and activates inherent emotions such as Darwin (1872/2007) refers to:

They have to want it though (David)

It’s like a human interaction [which allows Elizabeth] to understand them, feel what they feel. (Elizabeth)

I think it depends how close a person lets you get [being close to a patient allowed Kat to communicate information]

I knew that it would make a difference in her treatment (Kat)

Both David and Kat thought that a reciprocal relationship between themselves and their patients depended on the agreement of the patient. Kat

thought that it was about the intimate but professional relationship, which could lead her to understand the needs of her patients completely, a crucial element of a successful therapeutic alliance. This thought is upheld by all of the students, who thought that reciprocity between themselves and their patients leads to attunement to the patient's needs. Reciprocity according to all the students appears to be instrumental in getting to know the patient, their beliefs and their views. This leads to a deep understanding of how the patient wants to be treated, and allows positive regard and freedom of choice.

According to the students, this unique form of reciprocity within nursing sometimes occurs without the nurse knowing if the offer of help will lead to the act being mutually beneficial. Ideally, the reciprocal relationship that occurs within a nursing context requires a spirit of cooperation and emotional investment by both the nurse and the patient. This emotional investment may lead to a mutual and beneficial relationship (Molm, 2010). Although incurring reciprocal costs could be said to be part of a student's role when caring for patients (NMC, 2010, 2015), Howe (2013) believes that those costs could be personally worthwhile (if not immediately) if the student thinks that the cost will be recovered in the future. Although the spirit of reciprocity is that neither party is disadvantaged, the students tell me that their first concern is not if they are to benefit; their first concern is the wellbeing of the patient.

The students tell me that reciprocal connections with patients occur through effective communication. Effective communication appears to lead to a trusting and better-attuned relationship between them and their patients. This relationship according to Epstein and Street (2011, p.457) is of benefit to both the nurse and the patient as it "promotes a stronger belief in and commitment to a treatment decision" during the treatment journey. Getting to know the patient appears to help the students establish reciprocity. Reciprocity helps the patient as care can be better fashioned to the individual, as it involves the nurse taking into account the person themselves where their rights and beliefs are respected. The benefit of this approach could lead to a more contented patient, and the relationship is then more likely to become reciprocal.

All the students agree with Epstein and Street (2011) and the general thought that a reciprocal relationship within nursing is beneficial. Both Kat and David thought that even when a reciprocal relationship was not forthcoming, they could still look after the person. (The impact of an un-reciprocal relationship did not arise within Elizabeth's story.) This is what David and Kat said about un-reciprocal nursing relationships: "*I treat all the people the same*" (David) and "*I still look after them*" (Kat). What David and Kat are both saying is that when the reciprocal relationship between the patients is less than optimal, they feel that they can still provide the treatment and care that the patient needs. At first it may appear that David and Kat are contradicting the ethos of reciprocity and its role in attuning care to the individual. What I think that they are saying is that they can still provide care, however this care may be less than optimal as it may not be attuned specifically to the person. This thought reflects the theory of Smajdor (2013) who has said that care can be provided without knowing the patient; she does not specify if she has taken into consideration whether this care will be attuned. The important element appears to be that reciprocity leads to attunement and results in optimal care.

8.4 Attachment and caregiving systems

Closely associated with reciprocal relationships is the theory of attachment offered by Bowlby (1969/1982) and Clarke and Clarke (1998). Attachment traits are thought to develop from birth through the parent (or proxy parent)-child relationship, and to have a lasting effect on a person's ability to be accepting of compassionate care and compassionate love, and ability to give it to others. The three theorists suggest that attachment traits develop from the first encounters with main caregivers very early on in life. The traits are thought not to be static, but can change along the life continuum. This theory of attachment traits is reflected in the thoughts of the students as each expressed the importance of their emotional development throughout their lives. This appears to have impacted upon their ability to relate and care for their patients:

I think that things happen to a person in their life and it could start as a baby, things happen... I've had a great upbringing.

I'm sure that it has helped, I can relate to people, I'm not scared of showing my emotions. (David)

I've come from a loving family and I like to pass on some of that love to other people. (Elizabeth)

I was not that compassionate towards people and I was probably just emotional with my family. [But since commencing the programme Kate says that she is able to demonstrate] *compassion to everyone.* (Kat)

The students say that they believe that their family upbringing has had a positive effect on their caregiving systems, and all demonstrate the attachment trait that Bifulco and Thomas (2013) describe as secure. This appears to help them in their role as a student nurse. They share two factors: they all were brought up in families that freely demonstrated their emotions within their family units, and they all associate their positive upbringing with being able or wanting to share their compassionate emotions with the patients they care for. It appears that feeling comfortable with sharing emotions even with strangers may effect compassionate care.

Expanding upon this, David believes that the experiences that help him to relate to the needs of patients “*could start as a baby*”. This also suggests that he thinks that experiences throughout life can positively influence a person’s compassionate persona. Elizabeth refers to “*her loving family*” and is the only student who uses the word “*love*” to describe the compassionate and altruistic feelings that she has when looking after her patients. She thinks she is able to pass this trait on to her patients as she cares for them. Kat is the only student who says that prior to becoming a student nurse she was only comfortable with emotional encounters that occurred within her family. The programme has changed her beliefs and behaviour, and she is now able to “*show compassion to everyone*”. What the students are saying appears to uphold the theories of Bowlby (1969/1982) and Clarke and Clarke (1998), when they refer to the impact of social interactions on a person’s emotional development and attachment trait, not only as children but also throughout life.

These are pertinent points that the students make because if they are right then it may be possible to positively influence compassionate practice, as Seigel (2007) has said a person’s attachment trait influences their ability

to care. In their narratives, they suggest that it may be possible to influence or develop a student's attachment trait within their training. According to each of the students the attachment traits that they held before they started the course have positively influenced their activity within the programme and helped them demonstrate compassionate practice towards their patients. If they are correct, then any positive modification to any student's attachment trait may enhance compassionate attuned practice (Siegel, 2007b, p.1). It may even be possible to change a student's attachment style completely from being anxious, avoidant or anxious-avoidant: Mickelson *et al.* (1997) suggest that a person who holds these traits has challenges forming relationships with others, which will act as a barrier to helping and caring for a person. Even when a person has a secure attachment trait (Mickelson *et al.*, 1997), it could only benefit compassionate practice to take steps to nurture it.

8.5 Emotional labour

Student nurses have to deal with distressing situations every day. This can include something that a lay person would find distressing and yet a student nurse may look on as routine, for example changing an oozing wound dressing. Yet it is not their actions, the treatments and care that they give that students find most distressing. The students tell me that dealing with challenging situations takes its toll on them emotionally: it is the emotional connection that they have with their patients and their families that causes the most distress to them, and sometimes they find the emotional lability difficult to manage. As they develop emotional connections with their patients and families, the students appear to become vulnerable. This can cause them emotional suffering or, as Hochschild (1983) may say, they are immersed in a culture where emotional labour is common:

I keep my emotions professional, I try to help, but you know? That can be hard especially when you get close to a patient and their family. (David)

I have dealt with a lot of things but recently I dealt with something that completely knocked me. I mean it really knocked me. (Elizabeth)

If I can stop them suffering my pain goes too, I feel better. It's always about suffering, it is always about when I see somebody who suffers, the feelings that I get. I just wish I could do something to alleviate her suffering. My compassion has come out in my training because I have seen so many people suffering. (Kat)

They are all displaying tensions between their professional selves and what is expected of them as a student nurse (NMC, 2010, 2015). All find it difficult to balance the emotional reactions they experience as a compassionate human being with the expectations of the profession. It does not seem to matter how many times they have had emotional encounters and who they have them with: whether it be between themselves and a patient or their families, there are times when the suffering they witness negatively impacts upon them emotionally. They indicate that different emotionally challenging situations may result in similar emotions being evoked, but each encounter is somehow different, somehow unique. David says it is emotionally challenging *“when you get close to a patient and their family”*. He goes on to say it *“can be hard”*, indicating that he has had potentially psychologically damaging results. Elizabeth agrees and also thinks that emotions that she encounters are challenging, saying she has *“dealt with a lot of things”*. Dealing with many things within her job, Elizabeth hints at the emotional labour that she faces routinely, as does Kat when she refers to *“seeing people suffering”*. The word *“suffering”* exposes the immensity of the emotional turmoil that she often experiences as a student nurse and the toll that it has upon her.

What is evident from the all three of the students is that some emotions they experience come at an emotional cost. They appear to be suppressing authentic feelings and portraying feelings expected of a nurse as they are exposed to the suffering of others. Kat's words sum up what all the students say about the impact of compassion on their emotional state: *“my compassion has come out in my training because I have seen so many people suffering”*. Although seeing and being involved in distressing situations may in itself enhance compassionate care, the students say that it acts as a precursor to demonstrations of compassion. The encounters that trigger emotions that result in actions appear not to be without sometimes-

unseen costs, to the detriment of the students' psychological wellbeing and compassionate practice.

The emotional dissonance and the negative effect on their wellbeing have implications for the pedagogical approach to learning and managing emotional labour within their nursing programme. It is a health and wellbeing issue that if addressed could lead to a healthier nursing student and workforce, better equipped to deal with the psychological impact of tending to ill people. I share the concerns of the students that nursing can be an emotionally challenging career. Taking into account that Kat, David and Elizabeth are all third year students leads me to suggest that the earlier interventions to help support their emotional wellbeing are introduced, the better. The interventions could be integrated throughout the three-year curriculum, as it is obvious that emotional labour is an ongoing concern to the students. Supporting and equipping students with the relevant tacit knowledge is likely to help prevent emotional and psychological burnout. It may be through role-play (for instance) that students are able to share their knowledge of emotionally challenging situations and problem solve to promote their own and others' emotional resolve (Slevin, 1999).

8.6 Pedagogical approaches to compassion

Within each of their narratives, the students comment upon the pedagogical approaches used within university and clinical settings. These are important points as since the changes to nurse training (NMC, 2010) fifty per cent of the programme occurs in each of these settings. They each talk about the importance they place upon how experiential learning impacts on their professional knowledge and how this knowledge affects their compassionate practice. The pedagogical principles employed in both the university and clinical practice sometimes raise tensions within the students, due to what they think is the incompatibility or less than optimal use of pedagogical approaches in each setting. I first look across the cases in relation to their perceptions of learning within university spaces. The students say:

I think it links indirectly with skills. We did a lot about application scenarios through role-play... you get to think about things in scenarios before you go into the real world. (David)

We are taught and learn about compassion and use role-play to learn about it.... It does make you feel that you are not going into situations blind. (Elizabeth)

I think that through ethics and skills, role-play we learn things that affect care, but we do not learn compassion in university. How can you? (Kat)

Each student remembered that one pedagogical approach to teaching and learning about compassion was role-play. They say that its use promotes experiential learning in a safe environment and it can help develop the student's affective, cognitive and psychomotor skills (Selvin, 1999). We share concerns about the benefits of role-play and how university-based learning can positively influence their practice. The students tend to agree that it does what it sets out to do, as David and Kat associates role-play with skills, while Elizabeth is more confident that she learned about compassion through the facilitation of role-play. Associating role-play with skills acquisition suggests that professional knowledge and compassionate practice can in some ways be approached through role-play.

The use of drama has enabled each student to symbolically represent and explore their feelings around potentially challenging compassionate situations. Role-play has helped them consolidate their experiences with theoretical underpinnings, allowing them to connect the two in a safe environment and use their own imagination and experiences, along with those of others, to foretell how they might approach situations that arise in their future practice. David says, *"you get to think about things in scenarios before you go into the real world"*, while in the same vein Elizabeth says *"It does make you feel that you are not going into situations blind."* Both David and Elizabeth refer to this form of pedagogy as beneficial to their learning before they are faced with similar situations in practice.

The success of learning about compassion through role-play appears particular to each student, dependent on their ability to connect their learning within the university to its use within clinical practice. The connectionist approach to teaching which compassionate role-play is based upon is dependent on the individual's understanding and assumptions, their prior experiences, their learning style. This approach allows each student to

construct their own meaning, but their individual experiences of the situation add to the learning of the group (Dreyfus, 1981; Dewey 1933).

Kat believes it is beneficial to learn about care or caring for a person, but does not believe it helps a student learn compassion; she appears to see a difference in the delivery of care and the delivery of care with compassion. She is able to separate the two and, like Smajdor (2013), appears to see care as giving treatment that can be conveyed to a patient in an efficient manner. Like Benner (2004), she is saying that only when immersed in the authentic surroundings of clinical practice, where authentic experiences are generated, can true compassion occur. It is the application of the knowledge learned within the university that is put into context within the practice arena which appears important to all the students. All suggest that role-play is beneficial, and that using it they have been able to develop their affective and cognitive responses to challenging situations (Pence, 1983).

One connection pertinent to my research is the underlying association between how successful the students believe role-play is to their compassionate learning and their practice. I can make an association between their personal attachment traits and the value they put on role-play. It may be that attachment traits can impact upon the efficacy of role-play in student nurse training. To explain: both David and Elizabeth said that they have always felt at ease showing their emotions to others, while Kat said that she has learned to be emotional with others through her training. Within role-play students are vulnerable as they share reactions to emotionally challenging scenarios. This could initially disadvantage students like Kat until they become comfortable with sharing emotions in a learning environment. Although initially disadvantaging students, it could also benefit students who find it challenging to be demonstrative. Kat herself has said that she is learning to be emotionally comfortable with strangers; her attachment trait appears not to be fixed, but changing with personal experiences (Clarke & Clarke, 1998; Howe *et al.*, 1999).

8.7 Situated learning within clinical practice

Although learning through role-play is beneficial, all the students agree that their situated learning within clinical practice is the best place to learn about compassion:

The best experience of learning compassion you can have is being in practice. (David)

Learning from role-play isn't as good as learning from practice. (Elizabeth)

We do not learn compassion in university. How can you? (Kat)

Kat is the only one of the students who directly says that for her to learn compassion it has to occur within the clinical practice placement. It is in this authentic setting that they are able to witness and learn first-hand through experiential learning the complexities of compassion. As well as learning from situations, they are also able to benefit from their previous knowledge as they incorporate it into arising situations. They are demonstrating that they are critical thinkers as they illustrate an awareness that theory cannot be separated from experience or apply their theoretical knowledge to practice. The students agree with Gobbi (2009, p.82) who said that to develop as a professional within practice, a person needs to be exposed to clients and situations that involve “doing now” or learning and putting the learning into practice at a later date.

To illustrate their learning in practice Elizabeth and David recounted specific scenarios that had affected them as people and professionals. Kat referred to seeing other professionals treat patients compassionately and learning from them. As they told their stories, it emerged how challenging placements, incidents and the professionalism of staff had changed their view on compassion.

David highlighted that his view of certain patients had changed when he was placed in a situation where he cared for them:

I think it's the life experience of being in that situation; I think that being in that clinical practice is something that has changed and developed me. (David)

Elizabeth referred to a situation where she looked after a young man and his family after he had tried to commit suicide, and how she learned from it:

If I come across it again [referring to the scenario above] I probably won't be as upset because you have dealt with it before... it was awful, but you can move on from it and learn from it, take it in, deal with it and take it forward. (Elizabeth)

Kat told the story of learning from the actions of other nurses and says:

I think you can see it in nurses, all your mentors, you see the way that they treat patients... and you pick up on those things. (Kat)

Each student recognises the value of situated learning as they reflect on their experiential education within clinical practice. They are able to learn through their lived experiences; they cognitively use what they learn to support their practice and make sense of what is expected of them as student nurses. They are saying that they acquire skills as they navigate their practice, and highlight the importance of articulating knowledge in authentic situations that require responses (Benner, 2004). They also appear to be talking about learning through an apprenticeship model: learning from the experts within both university and practice settings (Wenger, 1998). What the students agree upon is that situated learning exposes learners to new experiences that help them develop professionally, as they progress from being a student to a registered professional.

They also refer to the benefits of being a reflective practitioner (Dewey, 1933; Schön, 1983; Boud *et al.*, 1983) as this pedagogical approach appears to be the key to putting learning into doing. This reference to reflection is evident in both David and Elizabeth's narratives and (more subtly) in Kat's words. All refer to learning using a connectionist approach: connecting their experiences, they learn and draw from them to support their present and future practice. By doing this, they are developing into critical thinkers, filtering their knowledge, deciding what is not only best for their practice but best for the patient as they address their needs. They are reflecting in and on practice; they are challenging their own preconceived ideas (Clapper, 2010).

The challenges they confront and their synthesis of the experience lead to an improvement in their clinical expertise. This improved approach to situations within practice is likely to be of benefit to compassionate practice. Each student learns the best approach to help patients compassionately. This arises as they examine their actions and the manner that others

approach situations. After experiencing or witnessing situations, they then select those actions that will benefit patients and constantly monitor their effectiveness.

8.8 The students value communities of practice

Closely associated with what the cross-case findings display regarding learning in practice is the value students place upon wards that exhibited traits associated with CoP (Wenger, 1998).

It definitely helps compassion be a part of a culture of care if everybody is on board... if patients are to get best practice and compassion, it's more than just team work, it's moving across professions, it involves everyone. (David)

That day was just one example of how we all worked together on that ward. The doctors, nurses, everyone, we complemented each other... it was like we were one. (Elizabeth)

I was part of the team on that ward, I could go to the doctor with information, I could go to anyone.... We learnt from each other. (Kat)

David, Elizabeth and Kat all refer to the different philosophies that wards adopt; they refer to the ethos of the team approach (NMC, 2014; Salas *et al.*, 1992). to learning and care provision, in contrast to the CoP approach (Wenger, 1988). These different philosophies affected not only the care provided to the patients, but also the students' learning and contribution to the care of the patients. The students are saying that although they do learn on a ward that uses a team approach, their learning is enhanced on a ward that adopts a CoP approach.

All the students describe what Wenger (1998) depicts as a CoP. David and Elizabeth refer to some wards being different to others they had worked on, as everybody across the disciplines worked together and not in silos or teams. Kat does briefly say, "*I was part of the team on that ward*", but then corrects herself and says that it was "*more than a team*" and that everyone worked together. Kat and David mirror Wenger and Trayner's (2011, n.p.) definition of a team as opposed to a CoP, when Kat says "*I think of us as nurses, the doctors, the physios [physiotherapists], all doing their own jobs, they have their tasks and we have ours*"; and David says: "*it's more than just*

team work, it's moving across professions, it involves everyone". Both envisage a team approach to care as being different professions working independently and not crossing boundaries.

All of the students thought that the cross-boundary professional and auxiliary working ethos of a CoP supported compassionate practice. David actually stated this, saying that everyone has to be "*on board if patients are to get best practice and compassion*". Elizabeth said "*The doctors, nurses, everyone, we complemented each other*": each person had a role to play in harmonising care and compassion on the ward. Both are highlighting that this approach to practice involves relationships, effective communication and mutual respect.

Although Kat said "*everyone worked together*", she actually went further in describing who she thought was instrumental to the success of the CoP. She included the patients themselves, as the patients contributed to the knowledge that helped staff provide optimal and individualistic care. It was through shared repertoires that the staff could learn from their patients and incorporate their knowledge into their practice (Wenger-Trayner & Wenger-Trayner, 2015). This appears to be a method of applying truly integrated and compassionate care, which reflects healthcare guidelines (DH, 2012a; NMC, 2010, p.4) to involve patient's thoughts, wishes, values and human rights in their care.

Each of the students illustrates that their educational experiences and trajectories of personal development within the university and in practice influence their learning and compassionate practice. They say that there are methods of teaching and learning that are more effective than others, citing experiential and situational learning. The professional knowledge of educationalists both within the university and practice affects the students' learning and practice. The ethos of a CoP approach helps the facilitation of compassion that occurs in both settings. Their educators and the culture in which they learn (Wenger, 2010) affect the students' professional knowledge and practice.

The students' thoughts have implications for the pedagogical approach to learning within practice placements and the university setting. The NMC (2010) suggest that CoP might be the way forward for students to learn

effectively within practice placements, and the students agree. However, the NMC stop short of suggesting that a CoP approach might also be applied within a university setting. The students suggest that the better environment for them to learn about compassionate practice is the practice placement. Considering this as an educationalist situated within a university setting, there is a need to look towards a pedagogy that is just as effective in the classroom as it is in practice. One way might be to capitalise on the ethos of CoP by nurturing best practices as students learn through peripheral participation within the classroom contributing to their and others' learning. A CoP approach might be able to facilitate students' learning via a pedagogical style which transcends both the university and clinical practice settings (Francis, 2013a; Wenger, 2013). Where this approach is encouraged, the students might become a group who share a platform where learning is collaborative in their quest to develop and create new knowledge that is not unique to their clinical practice.

Learning to be and being compassionate are complicated and affected by many influences. It is these influences that concern me as an educationalist and a nurse. I am aware that all adverse experiences do not ultimately result in negative learning experiences. The students tell me that they have learned from what they initially deemed 'bad experiences'. They turned them around to help them deal positively with similar situations as they arose, using reflection in and on practice as a tool to support their learning (Schön, 1987).

Chapter 9: Conclusion

My study exposed that compassion within the nursing profession is a topical but not a new subject: it is generally thought that nurses should be compassionate as they carry out their professional duties. There is little evidence within the literature that portrays how student nurses perceive compassion as they navigate their professional training from novice to expert (Benner, 1982; Dreyfus, 1981). The study has, through the perceptions of the students and my ethnographic influence, helped demystify what they think contributes to compassion within nursing. Compassion appears to be multifaceted and by helping to clarify what influences compassion the study illuminates and brings transparency to the pedagogical approaches used within the pre-registration nursing programme. Facilitating changes to the methods used within education may have a positive effect on how students learn about compassion and therefore on compassionate practice.

When Francis (2013a) wrote that student nurses lacked compassion, he implied that the manner in which nurses are trained for the profession was in some way to blame. He specifically focused on the degree-level training of nurses and implied that graduates were in some way less compassionate than nursing students trained before the compulsory degree pathway was introduced (NMC, 2010). He suggested that having a degree or being a nurse educated to a higher academic level somehow makes a nurse less compassionate. This theme of uncompassionate acts by student nurses was accentuated within the political and media arenas. A review by Willis (2012a) refuted these claims that the more educated nurses became, the less compassionate they were.

When I looked back into the history of uncompassionate care, my literature search uncovered that care deemed as less than optimal was occurring within the workhouses for the poor and the sick as far back as 1847. Tatham (1847) differed from Francis as he thought that the lack of compassionate care he witnessed was due to the limited education the nurses received before they tended the sick. It appeared that tensions between nurses, their education and their ability to demonstrate compassion was nothing new.

In the following part of this chapter, I conclude with my findings that have addressed my research questions

9.1 The impact of emotions

The students perceive that emotions that they experience within the arena of nursing are an important factor in compassion. They believe that emotions that encourage compassionate behaviour can be an inherent trait. They also think that emotions can be activated by exposure to events in which patients require their help: they are a response to observing and recognising the cues given by a suffering person, and lead to a wish to alleviate the person's distress. This emotional response is often referred to as empathy or having an empathetic reaction. The students do not think that compassion can be taught as they think it is inherent, but they do highlight the thought that empathy can be nurtured.

9.2 The importance of attachment

Attachment theory and its implications proved to be a substantial subtheme to the role of emotions. Each of the students said that they came from loving homes where they were unafraid to display their emotions. This exposure benefits their ability to be compassionate to strangers in their role as a student nurse. David and Elizabeth believe that this ability to demonstrate compassionate love was not specific to their role: it is events that they encounter as part of the role that provide opportunities to demonstrate the trait they have developed during their life. Kat, on the other hand, said that only since she started her nursing programme has she been able to demonstrate compassionate love to people outside her immediate family. This suggests that people's emotional resonance is not fixed in childhood, but is influenced by life events and experiences. The ability to develop emotional traits throughout life is important, as it implies that student nurses, if exposed to the right learning experiences and given the right support, can develop behaviours in which they are comfortable to demonstrate compassionate love to patients. It is when student nurses are supported by educationalists, within both the classroom and practice, that they are enabled to explore their emotional dispositions. It is through a connectionist approach

that the teacher facilitates the learner, influencing them in order to make connections to how they feel and to how they demonstrate their feelings appropriately to patients (Dewey, 1938).

9.3 The role of reciprocity

Reciprocity and the cooperation that occurs between students and patients are important factors within compassion. The students value reciprocity and it evokes feelings of satisfaction and pride in the care that they provide. Positive reciprocity, they say, leads to attunement with and for the patients: they get to know the patient and can apply this to how they care for them. Reciprocity from the perspective of both the student and patient is important if students are to give and receive compassionate treatment. The students say, however, that sometimes patients rebuke them for what the students perceive as compassion, but add that this is not a reason for them to withhold compassion and treatments. When this occurs they adjust their mindset and their delivery of care to attune to the patients' requests. The students are genuinely concerned about the wellbeing of their patients, and try to uphold compassionate practice – sometimes, they say, at an emotional cost to themselves.

9.4 Emotional labour

Emotional labour is evident within each of the student's narratives. Hochschild (1975/1979/1983) puts forward the theory that emotional labour is a negative and psychologically damaging aspect to emotionally demanding jobs, but the students see it slightly differently. This is not to say that the students do not find their roles emotionally challenging, as they tell me they do: they say it is the emotional labour they experience through distressing events that helps add to their compassionate knowledge. It is the continued and relentless exposure to distressing situations that, they say, takes its emotional toll. I can relate to what they say as a nurse: the suffering that is witnessed by a nurse is an integral part of caring for the patient. It is more common that a patient is in distress than not; it is as though suffering is a prerequisite to being a patient. The suffering that I have witnessed in patients can originate from a physical or emotional difficulty, but that does not matter:

suffering is suffering, and each affects the physical and psychological wellbeing of the patient. The main objective is to treat the cause and provide support to relieve the symptoms; this is when limited resources may adversely affect the nurse and the patient. Learning how physical or psychological health affect each other may be addressed by implementing a biological, psychological and sociological approach to problem solving and care planning (NMC, 2010; Benner, 2004).

9.5 The value of experiential learning

Acquiring compassionate and tacit knowledge through experiential learning is beneficial. In some cases, the students say, it leads to changes in their behaviours and beliefs, and equips them with the experience to professionally address, through reflection (Schön, 1983), similar events when they arise. Witnessing suffering triggers a personal emotional response that leads the students to act to minimise the harm. It is important to me that the emotional wellbeing of the students is addressed which if insufficiently supported can negatively affect their psychological wellbeing. This leads me to suggest that effective psychological support is needed to help students in their emotionally challenging roles. This might take the form of using reflective practice, supported and guided by a teacher both within practice and within the university setting, to explore and address students' emotional concerns in a non-threatening environment.

9.6 The value of role-play

Each student turned their attention to the pedagogical approaches used within university spaces to teach and learn aspects of compassion. All focused on the method of role-play as the pedagogical approach that they associated with the gaining of knowledge around compassion. All of the students felt that although it was not as effective as learning within a clinical practice environment, it did have a place and exposed them to experiential learning where they could imagine, think and learn in ways important for compassionate practice to occur. This higher order and deep learning, facilitated through experiences, also provides the students with a theoretical and contextualised knowledge base pertinent to the profession. The students

tell me it is the nearest that they come to being enabled to think and solve problems away from the intensity of practice. This mode of learning helps them prepare for the real life challenges of compassionate practice where patients, and student nurses, are prone to increased vulnerability (Benner, 1982, 2004, 2015).

9.7 Learning within the clinical setting

The students, after discussing the value of role-play, spoke of the importance they place upon their parallel learning within practice (NMC, 2010), describing what they envisage as a means to a successful skills-based apprenticeship within clinical practice. They saw this as developmental, somewhere they learned how to function and think like a nurse from members of their own and other professions. All of the students differentiated between wards that operated on a team approach as opposed to a CoP approach (RCN, 2014; Lave & Wenger, 1991). They each preferred a CoP approach, stating that they learned more from and could impart their knowledge to their willing and enthusiastic co-workers within the borderless learning and teaching that occurred between professionals and non-professionals. The learning on certain wards involved more than integrating theory-based knowledge acquired within the university learning spaces; it involved learning by means of integration into the culture, learning from and practising with other disciplines. The CoP approach was instrumental, not only in their learning but in making them feel valued: their opinions and knowledge mattered to other professionals.

9.8 Final thoughts

A student nurse's theoretical education is traditionally set away from the domains of practice, and there is a long-standing dialogue about the theory-practice gap within nursing. This gap was talked about when I was training, yet is still evident within the students' stories. They say that although the teaching of compassion within the university setting does help them, it is only in clinical practice that they truly experience and learn what it means. I have a responsibility as a professional nurse and nurse educator to listen to what the students say, and to learn from their perceptions around compassion. My

main objective is to enable their transition from entering the profession as novices, providing them with the means of becoming professional and compassionate nurses at the end of their training. This is particularly challenging when nurses are portrayed as being uncompassionate, and made worse if we are to believe Francis (2013a) that a higher level of education in nurses negatively affects compassionate nursing practice. It is difficult for the nursing profession to maintain its professional integrity under such attacks.

Because of the complexities of compassion and the methods employed to train student learners I do not offer any one solution. My study and the all-important perceptions of the students reveal compelling evidence which helps support changes to the way that educationalists approach the enigma of compassion within nursing. The students' perceptions of compassion as they navigate the nursing programme emphasise discontinuities, highlighting their emotional disturbances and the pedagogical approaches utilised to teach and learn compassion in the university learning spaces and clinical practice.

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